

POWER AND CONFLICT
IN
PRIMARY MEDICAL CARE

A CASE STUDY OF THE MICRO-POLITICS OF HEALTH CENTRE PRACTICE

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I declare that I alone have composed this
thesis, and that it is based on my own work

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ABSTRACT OF THESIS

This thesis offers a case study of the attachment of a social worker to a pair of health centres serving a Scottish New Town population. The study is located within the discussion of the differences in power in inter-occupational relationships within the health centre setting. A number of key issues are identified. It is argued that the ability of the social actor, individuals and groups, to achieve the outcomes they prefer gives some insight into the nature and pattern of power relations. In doing this I draw a distinction between different forms of power. Rather than relying upon traditional claims to competent (expert) and legitimate (social-legal) authority, the GPs use various strategies, strategic and tactical, to acquire power and subordinate other occupational groups. The study also identifies a number of structurally determined resources of power which the social worker could have used. Yet the social worker chose not to exploit these resources. Some reasons why this did not happen are discussed.

This calls upon intensive fieldwork carried out within the health centres over fourteen months. The methods used to collect data include: semi-structured interviews, participant observation and the analysis of medical records.

The thesis argues that the GPs' power within the health centre is considerable. They are, by and large, more successful at achieving the decision outcomes they prefer. Their power in relationship to others is, however, limited in its comprehensiveness, intensity and extensiveness. The doctor does not exercise total control in the organisation. The thesis shows that the pattern of power relationships

within health centres is too complex to deduce from the existing literature. It therefore reveals a need to formulate more complex theories about the nature and distribution of power within health centres and its impact upon the division of labour within this setting.

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INTRODUCTION

BACKGROUND

I first became interested in the social organisation of general practice, and the division of labour in health centres in particular, in 1974 while working in West Germany as a research assistant on a cross-cultural, comparative, research project which traced the historical development of group general practice. (1) From a review of the British professional literature and historical studies of the emergence and growth of the National Health Service, it appeared that general practice had just emerged from a turbulent period, from 1950 to 1970, of self-doubt about the role and place of general practice in the NHS and conflict over the pay, conditions of service and the status of the general practitioner (Dopson, 1971; Eckstein, 1959; Ferris, 1975; Stark Murray, 1971).

Concern was expressed within the profession of the difficulty of attracting newly qualified doctors to general practice (2) and the relative decline in the total number of doctors practising in general medical practice (3). Such trends, combined with the so-called 'Brain Drain' of doctor emigration, were interpreted as an outward sign of the physicians' disaffection of practising within the NHS especially general practice.

By 1975, however, the trend of doctors away from entering general practice had reversed and general practice moved from 'crisis' to 'stasis'. This posed the question "what led to the recovery of general medical practice over this relatively short period of time?"

What was of more direct interest to me, however, was the changing shape of general practice; more specifically, the transition from the delivery of general medical services by independent, single-handed general practitioners working from shop-fronts and front rooms, to a more 'organised' form of general practice based upon groups of doctors working with ancillary and para-medical staff in converted premises and purpose built health centres.

In 1950 there were, in Scotland, 1,165 principals operating single-handed practices and a mere 351 principals working in groups of three or more. By 1974 this pattern of practice had reversed; only 454 principals operated single-handed practices, while 1,175 principals worked in groups of three or more. (SHHD, 1975)

The GP, working alone, with limited contact with the rest of the profession, enjoying his own priorities and clinical and administrative freedom unconstrained by the demands of working in an organised environment, without the support of other medical and non-medical staff, had undergone considerable change. While the tripartite structure of health and welfare services, underwritten by the national Health Service Act (1946), may have done much to reinforce the GP's traditional role and form of practice organisation, increasingly that role appeared to be undermined as the GP was drawn into a more complex form of practice organisation, the group practice. The rapidly expanding knowledge about man as a physical and social entity, and the impact of man's social, psychological and environmental state on his physical well being, combined with rapid technological change, meant that medicine was unable to accommodate the lone practitioner in practice and ideology.

In effect the general practitioner was pressed to reconsider his position within the health service and his mode of practice organisation. This trend was reinforced by economic considerations public, professional and personal.

For example, following the publication in 1966 of the Family Doctors Charter, changes in the terms of service were established: the 'pool' system of remuneration, whereby the Government made available a pre-determined amount of net remuneration per practitioner for general distribution, was replaced by a system which took into account the physician's workload, his responsibilities, and his conditions of service, including a group practice allowance for those GPs working in groups of three or more, his experience and practice expenses. This led to a system which rewarded those doctors who worked in groups, who attempted to make improvements to their surgery premises and facilities, and who employed ancillary members of staff. (Forsyth, 1973)

Legislation was also passed (National Health Service Act (1966) to enable Health Ministers to set up an independent General Practice Finance Corporation to make interest free loans to doctors to assist them to set up group practices; to help newly qualified doctors provide or acquire a share in surgery premises: to alter, enlarge, improve or repair surgery premises; and to repay any loans they had incurred for the purposes outlined above. These, and other changes inside and outside medicine, served to underline the important part that professional interest and the negotiating power of physicians has to play in the development of the social organisation of medical care systems.

Another change in general medical practice which took place during the late 1960s and 1970s was the growth of the health centre movement. In Scotland in particular the commitment to a health centre building programme clearly figured large in the plans of both the Government, the Ministers of Health and the profession, for rehabilitating the image of general practice.

Although the concept of health centres had been around, in one form or another, for 50 years, since the publication of the Dawson Report in 1920, neither Government, central and local, nor the profession had shown much sustained enthusiasm for the idea. In 1966, however, the General Medical Services Committee (Scotland) took the view that the health centre was an ideal means of bolstering the image of general practice and improving the status and conditions of service of the general practitioner, thus bringing to a halt the drift of both newly qualified and established physicians away from general practice. The Committee argued that the future of general practice was dependent on the functional integration of all parts of the National Health Service; and where appropriate that such functional integration could be best achieved by the provision of health centres. (SHHD, 1966)

Between 1953, when the first health centre came into operation in Sighthill (Edinburgh), and 1969, 12 health centres were opened. Yet in the five year period from 1970 to 1975 another 63 health centres were established and in operation with another 100 centres at various stages of planning or construction (Common Services Agency, 1975). In terms of manpower, by 1975 over 400 principals were practising from health centres serving a patient population of approximately 1 million people

or 1/5 of the general population. (Scottish Information Office, 1975) (4) Clearly the initial fear amongst many practitioners that entry into state financed health centre buildings would pose a serious threat to their clinical autonomy and independence (British Medical Association (Scottish Office, 1977) was somehow overcome with respect to a significant minority of practitioners.

What was of particular interest to me was the idea that the health centre, perhaps more than any other initiative undertaken at the time, gave concrete expression to the idea of comprehensive integrated general medical care. Health centres were seen as an ideal means of developing a multi-disciplinary approach to the care of the 'whole patient'. It appeared from the literature, however, that it was never really made clear what the relationship between the GP and other health and welfare occupations was to be. Indeed the relationship between the different occupational groups practising from health centres was seen as so problematical as to be described by one writer in pathological terms (Beales, 1978). The DHSS (1969) on local authority nurses argued that health visitors, especially those attached to doctors' surgeries, required the support and understanding of GPs in what they do and that this does not often happen. GPs were found to be annoyed that the field of work of the health visitor was subjective and that they were not able to delegate or monitor it. A number of other studies have shown that there was much conflict, dissension and misunderstanding within and between the health and welfare services (Walker and McClure, 1969; Frith, 1975; Roy, 1967; Tibbet, 1975; Gilmore et al., 1974). I was struck at the time by the diverse, often competing, interests that were hoped to be served by health centre practice by various occupational

groups, and the conflict rather than consensus that ensued when members of different occupational groups practised from a common setting of the health centre (Beales, 1976).

Thus, when I returned from West Germany to take up a post-graduate place in the Department of Sociology, Edinburgh University, I brought with me many questions about the division of labour of general practice, the role that professional ideologies and professional interest have to play in the social organisation of health centre practice, and the relationship between the GP and other allied medical and lay workers in the delivery of primary medical care services.

After an extended period of negotiations with what I thought at the time were the representatives of two health centres, agreements were reached that I would spend a period of six months in each of the centres. (5) Unfortunately the fieldwork did not proceed as I had hoped. There were a number of problems associated with the study, not least the fact that it was my first experience of doing fieldwork in a front line, generally hostile, medical organisation.

In addition I was soon to discover those who had acted as 'representatives' for the two centres during the period of negotiations did not, in fact, 'represent' the views of all of their colleagues and staff members nor had they informed all of their colleagues of my impending arrival. Thus, when I joined the centres I was greeted with at best apathy and at worst outright suspicion and hostility by certain practitioners and groups of workers, eg nursing staff.

Finally I entered two research settings whose organisational 'climates' were fraught with intra- and inter-professional tension,

hostility and conflict. In both cases allied health service staff, particularly health visitors, had adopted a 'siege mentality' towards the doctors and had withdrawn from co-operative work with the doctors in order to carry out their tasks independently. There were, in addition, obvious factions of doctors within the centre who conflicted and competed with each other. While the relationships between different occupational groups was of great sociological interest, the respondents chose to put on a 'brave face' during the semi-structured interviews which bore only a passing resemblance to what could be observed of their behaviour. My efforts to penetrate 'beneath the surface' (Fletcher, 1974) were blocked by individuals and groups who were intent on thwarting the efforts of the 'outsider' to observe certain strategic decision-making groups within the health centre, eg Health Centre Management meetings, group meetings and the like.⁽⁶⁾

Nevertheless this experience of working in the field proved to be an invaluable educational and training exercise for future research. Firstly, it taught me much about establishing and maintaining field relationships and the need to constantly work at 'negotiating' a role within the research setting. Secondly, it taught me how to exist and function in medical settings, or as Lacey (1976) so graphically puts it; 'to enter in (to the setting) and take punishment until he or she had learned to survive' (p.66). Thirdly, it served to whet my appetite still further for knowing more about the nature of power and influence relations within the health centre and the impact that such relations have on the social organisation and the division of labour within this setting. Finally, it provided me with the necessary 'credentials' to take up further research in this field.

One month after I had come out of the second centre I was offered the opportunity to investigate the attachment of a full-time social worker to two health centres serving a Scottish New Town population. The findings from this study form the basis of this thesis.

The study came about as a result of an approach made to Edinburgh University by executive officers of a Scottish Region's Social Work Department and Social Work Services Group (Scottish Education Department). This initial approach stemmed from their desire to know more about what happens when a social worker is introduced into the primary medical care setting. Although there are a number of published reports on attachment schemes (Goldberg' & Neill, 1972; Forman and Fairbairn, 1968; Corney and Briscoe, 1977a, Corney, 1980a; Faulds, 1976), they felt that more detailed and comprehensive information about the operation of a local scheme would be of value to the Department and its planners.

Goals of the Attachment Programme

Preliminary discussions with the executive officers engaged in the setting up of the experimental programme revealed that the primary goal of the programme of attachments was to improve the working relationship between social workers and primary medical care practitioners working at the grassroots level of service delivery.⁽⁷⁾ They were aware, as various studies have shown, that the contact between health and social work practitioners is characterised more by conflict than co-operation. In addition, by setting up a programme of attachment, they wished to give concrete expression to the various documents which have exhorted

practitioners and administrators from various fields to work co-operatively with each other; to engage in a collaborative approach to service delivery; and to integrate their services as and when the needs arise (DHSS 1959, 1967, 1976, 1978a).

The primary goal of improving inter-professional relationships was predicated on the attachment achieving a number of secondary goals which were regarded as necessary prerequisites, or instrumentalities, for its success; these include;

1. Educating members of the primary medical care team about the role and skill of the attached social worker;
2. Educating them about the professional activities of social workers and the nature of social work practice in general;
3. Changing the attitudes of primary medical care practitioners toward social work and social workers in a positive, otherwise unspecified, direction.

The goals of the attachment programme were not, generally speaking, clear-cut and precise, nor were the goals aimed at achieving highly specific ends. Rather the objective of the programme was to bring about non-specific changes for the better in the social work--general practice relationship. Moreover, the support and interest shown by the executive officers and the participants themselves for the research programme created an ideal opportunity for me to pursue my own research interests in such a way that my 'agenda' could be effectively accommodated within the general objectives of the 'action' oriented research design.

The Study

The study had as its primary objective the investigation of the power and influence relationship between general practitioners and para-medical and lay staff. Particular emphasis was placed on the medicine--social work relationship and the impact of power relationships on shaping the division of labour in the health centre. The study took the form of a longitudinal case study of the attachment of a social worker to the health centres. The investigation was broken down into three phases which in practice were subject to considerable overlap. In the first phase, the pre-attachment phase, material was collected on the participants' view of the social work--medicine relationship, their understanding of the nature of social work practice and what they hoped to gain or achieve as a result of the attachment (their initial preferred outcomes). The second phase of the research programme concentrated on collecting relevant material about the social worker's experience of working in the health centre in close proximity to members of the medical profession. In addition the study examined the attached social worker's relationship with her area team based colleagues and superiors. The third phase investigation attempted to assess the extent to which the different individuals and groups achieved the outcome they desired and the way in which their initial objectives were modified in light of their experience of the attachment.

The Attachment

The first, planned, full time attachment of a basic grade social worker took place in the last week of December 1978 and was the first of two experimental posts. As a result of the keen interest shown by two

health centres serving adjacent districts in a Scottish New Town for the proposed scheme, the decision was made that the post would be split between the centres so that the attached worker served each on a part-time basis.

Supervision of the basic grade worker was carried out, along traditional lines, by a designated senior social worker based in the local social work department. This arrangement brought the attached worker into the department's system of line management. Unlike other basic grade workers, however, the attached social worker also had monthly consultation sessions with the department's executive officers engaged in the planning and setting up of the programme, who provided an additional level of support and advice.

The attached worker's workload was generated almost exclusively from health centre referrals.

The Setting : The New Town

The area, which is located in the central industrial belt of Scotland fourteen miles from a large urban centre, was designated a New Town in 1962, and had at the time a population of approximately 2,000 people, the majority of whom lived in the environs of an old shale mining community. At the time of the study the population had grown to approximately 33,000 inhabitants. Approximately 83% of the population were under 45 years of age with almost 40% under the age of 15. Less than 5% of the population were over 65 and approximately 1% were over 75. Most of the people who came to live in the town were young married people, in the main family-building age groups. The average household

size was 3.4 persons per household compared with 2.9 persons per household in Scotland. This reflected the high proportion (58.8%) of households comprising parents with children.

Compared with the Region and Scotland, the New Town population had more of its workforce engaged in manufacturing. Manual workers comprised a larger share of the labour force (approximately half), and skilled manual workers formed the largest single group of workers in the town.

Household Heads Social Classes I to V, December 1978

Social Class	%
I	3.3
II	14.4
III non-manual	13.7
III manual	42.7
IV	19.8
V	6.1

The Development Corporation estimated that 39.5% of the total were in employment and 4.1% were registered unemployed. This represents a working population of 43.6% compared with 45% for Scotland as a whole. The proportion of the working who were unemployed (the unemployment rate) was 9.2% compared with 7.4% for the Region and 8.9% for Scotland as a whole in 1976. This figure reflected the high rate of unemployment amongst school leavers. Indeed, at the time of the study youth unemployment stood at 19.4% in the New Town.

The Districts

The two districts served by the health centres differed markedly from each other despite their close geographic proximity. District A was the first district of the New Town to be completed in 1968 and was composed of both low density and high density housing stock. The high density flats were based on a new approach to housing design, characterised by the extensive use of timber and flat roof construction. Within a matter of two years the weaknesses of the construction material and design were becoming evident. The buildings showed signs of poor weather-proofing, damp, and peeling paintwork. In addition the centre of the district suffered from the deprivations commonly associated with urban decay, official neglect and vandalism. District B, on the other hand, completed in the mid-1970s, was an area of low density housing stock of traditional Scottish peaked roof design, with open areas and well tended domestic gardens.

District A was known to all of the local health and social welfare services to be used by the Development Corporation as an area of transition, a starting point for newcomers to the area who in time would disperse to the more salubrious parts of the town, and as a 'dumping ground' for 'problem tenants' and those who had fallen on 'hard times' or were unable to keep up with the higher rents in other parts of the town.

The Health Centres

Health Centre A, situated in the oldest district of the town, was established in 1969 and was the base for the development of a planned, integrated health care system serving the local population. The centre was situated next to a grey slab-like shopping precinct and faced the

tall chainlink fence of one of the town's comprehensive schools. Like the houses, the school and the shopping centre which surrounded it, the health centre was occasionally subject to acts of vandalism; the gray pebbledash walls acted as a 'canvas' for the local area's young graffiti artists and it suffered the occasional stone through a window and break-in.

Health Centre B, established in 1971, in contrast, was located in an open area fronted by well tended private back gardens and set in spacious surroundings amid some of the town's best housing stock. The health centre rarely suffered the deprivations experienced by its near neighbour.

The Organisational Climate of the Health Centre

It is difficult to put into words but the two centres differed markedly in their tone and atmosphere; it was as if they reflected and were shaped by their surroundings. Health Centre A was a single storey building whose design and fabric did little to engender a sense of warmth; like the proximate shopping centre it had a gray pebbledash exterior whose finish showed the deprivations of time, the elements and the unwanted attention of the local 'artists'. Further, as the first health centre to be constructed in the area the interior design of the building paid little attention to the needs of those who worked within it and the patients who presented for treatment.

On either side of the reception area were double entry doors which were, during periods of inclement weather, a source of cold swirling draughts which passed through the centre. Settlement of one side of the building meant that during periods of heavy rain a 4 inch pool of water

formed at one of the entrances, which both patients and staff had to negotiate when they entered the centre. Patients waiting to see the practice nurse, whose room was situated to one side of the reception area, were expected to take one of the few uncomfortable seats that were available and wait positioned between the two entry doors. The small windows, set high from the floor in the consulting rooms, meant that in the absence of artificial light the better part of the centre was dark and gloomy. In addition the practitioners were plagued by the problem of poor soundproofing. When consulting with patients care had to be taken not to be overheard, and not to overhear, by colleagues practising from the next room. At times it appeared that the austere setting was reflected in the attitudes of staff toward the patient population. The physicians occasionally acted and spoke as if they were under siege by their patients. The reception staff also appeared harrassed and acted in a brusque offhand manner, and their approach to the patient was often formal and impersonal.

Health Centre B was more modern and the design owed much to what had been learned from the experience of the participants working from the first centre. The external finish of the building was in good condition and its overall appearance was enhanced by a white finish. The entrance to the health centre had a glass vestibule which protected those who worked within from adverse weather conditions. Each practice area, at either end of the building, had a circle of seating for the waiting patients and while the area did not benefit from natural light this was compensated for by the use of bright strong colours on the furniture and fittings. The doctors' consulting rooms also benefited from standard size windows which were set four feet off the ground.

This added to a sense of openness as opposed to the more claustrophobic atmosphere of Centre A. Staff relations and the relationship between health centre staff and their patients was, with a few exceptions, less formal than at Health Centre A, and characterised by a high degree of relaxed friendliness. There was, in addition, a sense of esprit and high staff morale which was in some ways lacking in the other centre. Staff also appeared less inclined to disengage from one another, a pattern of behaviour which was also much in evidence in the older of the two centres.

The Social Organisation of the Health Centre

Centre A was the base for six principals and a variety of full-time attached staff including: health visitors, district nurses, a community psychiatric nurse, a community psychologist, in addition to secretaries/clerical workers and a health centre administrator. The practice had a patient population of approximately 9,000 persons.

Health Centre B had a patient population of approximately 11,000 persons.⁽⁸⁾ There were eight principals and a staff structure similar to that of Health Centre A, with the exception that the centre did not have a fully attached community psychologist.

Both centres had a wide range of facilities including: dentistry, physiotherapy, speech therapy clinics, relaxation and mothercraft clinics. Moreover, the centres were the focus of different forms of technological innovation; like the hospital, the centres acted as a test-bed and proving-ground for feature-card registers, A-4 Problem Oriented Medical Records and later, microprocessors.

The Conjoint Appointment of the Doctor

The most interesting feature of these centres is the conjoint appointments of the doctors who, aside from carrying out their functions and duties as general practitioners, also held specialist appointments in the local district hospital. The specialities represented in the two health centres include: medicine, paediatrics, obstetrics and gynaecology, psychiatry, geriatrics, anaesthetics and community medicine. As a result of these unique appointments the doctors were able to introduce hospital-linked specialty services into the health centre.

The impact of this arrangement on the attitude and the behaviour of the physicians should not be under-estimated. Their specialist appointments placed them in an eminent sector of the profession, the hospital, the central focus of modern medicine where medical advance is seen to take place and where the networks of professional power are based (Dingwall, 1982). The status conferred upon the doctor as a result of his appointment to the hospital provided him with a strong sense of professional security. At the end of one working day, some months after the start of the attachment scheme, one doctor observed:

"Yeh, I guess you could say that we're pretty secure, we don't really have to worry about our status in the health centre or in general for that matter. We work in a pretty special set-up here and we have the hospital appointment. Mind you, we did run into some problems with the hospital staff, with the consultants, at first. They really didn't know what to make of us. But that's settled, ... I guess you're right, we don't feel especially threatened by the idea of

someone new joining the practice team ...
That doesn't mean to say that we're
complacent!" (Dr Hall)

The security in status mentioned by the practitioner above was not unique, the majority of the doctors felt relatively confident in their relationships with para-medical and lay workers.

The physicians actively encouraged para-medical and lay staff members to experiment with new approaches to patient care and to take an active part in the development of the health centre's services, so long as they carried out the duties which the physicians expected of them, a point I will return to in a later chapter. While some of the participants may have felt threatened by some new initiatives, another point I will return to in a later chapter, they were nevertheless prepared to 'have a go' and 'see how things work out'. In part the willingness of doctors to countenance change within the health centres owed much to status conferred upon them by the conjoint appointment.

The Participants

The names I use in referring to people are all pseudonyms, which are arranged in alphabetical order so as to denote the health centre. The names of the physicians, their specialty and the health centre in which they worked are as follows:

Health Centre A

<u>Name</u>	<u>Speciality</u>
1. Dr Able	Obstetrics/Gynaecology
2. Dr Baker	Obstetrics/Gynaecology

<u>Name</u>	<u>Speciality</u>
3. Dr Craig	Paediatrics
4. Dr Deans	Paediatrics
5. Dr Elder	Psychiatry
6. Dr Fair	General Medicine

Health Centre B

7. Dr Gold	Psychiatry
8. Dr Hall	Medicine (with Geriatrics)
9. Dr Ivory	Anaesthetics
10. Dr Jones	Obstetrics/Gynaecology
11. Dr Kelly	Psychiatry
12. Dr Lamb	Anaesthetics
13. Dr McAdam	Community Medicine
14. Dr Nelson	Paediatrics

Both health centres provided a base for a wide range of medical and lay staff. Owing to the limitations on time and other resources, interviews were restricted to the following individuals:

Health Centre A

<u>Name</u>	<u>Occupation</u>
1. Nurse Art	Health Visitor (HV)
2. Nurse Brown	Health Visitor (HV)
3. Nurse Curry	Health Visitor (HV)
4. Sister Dollar	District Nurse (DN)
5. Sister Edge	District Nurse (DN)
6. Sister Flower	Community Psychiatric Nurse (CPN)
7. Ms. Grant	Community Psychologist (CP)

Health Centre B

8.	Nurse Henry	Health Visitor (HV)
9.	Nurse Innes	Health Visitor (HV)
10.	Nurse Jade	Health Visitor (HV)
11.	Nurse King	Health Visitor (HV)
12.	Sister Lite	District Nurse (DN)
13.	Mr Miller	Community Psychiatric Nurse (CPN)

Soon after the start of the social work attachment scheme, three of the health visitors, Nurses Henry, Innes and Jade, left their respective posts. Later in the year these vacancies were filled by three recently qualified health visitors who were interviewed with an edited version of the original interview schedule.

14.	Nurse Norton	Health Visitor (HV)
15.	Nurse Osborn	Health Visitor (HV)
16.	Nurse Park	Health Visitor (HV)

In the planning of the research design I decided to interview all management grade social workers (senior social workers and above) and a sample of the basic grade social workers. Unfortunately, as a result of last minute changes in the attachment programme, this was not possible, and pre-attachment interviews were restricted to:

- (1) The Area Team Leader, Ms Argent, who, in the initial stages of the attachment, acted as the attached worker's senior social worker:
- (2) Mr Carson, a senior social worker, who took over the responsibility for supervising the attached worker at a later

- stage in the programme; and
- (3) Ms Bishop, the attached social worker.

In addition informal discussions took place with the two remaining senior social workers and other members of the area team, individually and in groups.

Within the limitations of this study, it is not possible to know how representative the findings are either in general or at the level of the area team. However, it is possible to make some useful observations about the social work viewpoint of their relations with the health centre and their perspective of the attachment programme.

Methodology

Any study of groups or organisations may have one or both of two focuses: it may be individually oriented or group oriented. With respect to the former focus, characteristics of the individual are identified and the relationship between these characteristics and the individual's position in the social network may be scrutinised. In the latter case, the focus is not so much on the individual members of the group as on the structure or relational properties of the group which is taken as the basic unit of analysis. Given the objectives of the research project outlined in an earlier section of this chapter an attempt was made to encompass both within the framework of the same research project.

A number of different types of field strategies were employed in

order to obtain the relevant data, including:

1. Focussed semi-structured interviewing;
2. Participant observation;
3. Enumerations; and
4. Analysis of documentary evidence.

1. Semi-structured interviews

The decision to use a focussed semi-structured interview was justified on the grounds that my interest extended beyond collecting data about the rational elements of the participants' knowledge and understanding of topics related to social work and the attachment programme. The study was also interested in gaining insight about the nature of the actors' intentions, their preconceptions and the influence of professional and personal interest. The use of a semi-structured interview permitted the introduction of probes which tapped these, and other areas, and allowed the respondents the opportunity to clarify and expand their views. (Institute of Social Research, 1969). The approach also allowed the respondents to make 'off the record' remarks which sensitised the researcher to important new issues, and at the same time maintained the confidentiality between the researcher and respondent.

Probes were generally used to stimulate discussion and obtain more information from the respondent when their answers were unclear, when they said something that had a variety of different meanings, when they conflicted with other information or when the answer was incomplete when they provided only a partial response to the question. The probes took a variety of forms and included; an assertion of understanding and interest in what the respondent had said; repeating the respondent's

reply 'Now you mentioned that from your point of view the attached social worker should have a commitment to the primary care team. Could you amplify what you mean by 'commitment'?' and by neutral questions "I'm not sure what you have in mind here. When you say that the social worker has a role to play in the psychiatric team do you mean? ... "

A recent study of the roles of staff in voluntary organisations (Lenn, 1984), highlights the limitations of using semi-structured interviews for data collection. The disadvantages of this method are:

1. Problems arise when attempts are made to handle the diversity of the material;
2. New ideas emerge which could be developed in later interviews which cannot be raised with those already interviewed; and
3. Questions may vary between interviews so that respondents answer different questions.

All of these problems were, at least partially, offset by the fact that more than one technique for the collection of material was employed. This made it possible to substantiate the data by material drawn from other sources (eg participant observation.) The use of more than one source of data, 'triangulation', (Smith, 1975; Denzin, 1970; Becker, 1941) proved a useful check on respondents who may forget information (Baddeley, 1976, 1979) or tailor or distort their responses (Rathje and Hughes, 1975).(9) Further, as the researcher was based in the centres for a considerable period of time (seventeen months) new ideas which emerged in later interviews were taken back and discussed with those who had been interviewed.

The study initially sought to describe, through interviews and documents, the formal and informal organisational structure of the health centres. Attention focussed on the collection of material which related to the:

1. Physical space and layout of the centres;
2. Facilities and equipment;
3. Staffing: numbers, designations, roles;
4. Clinical organisation; and
5. Administration and clerical support.

While a description of the formal structure of the organisation is a useful starting point for data collection it is axiomatic within the organisational literature that the empirical reality of an organisation often does not match the formal prescriptions laid out in flow charts and administrators' definitions (Sofer, 1942). Health Centres, like hospitals and University Departments, are formed and maintained as a consequence of the on-going negotiation of its members (Strauss et al, 1964; Beales, 1976; Smith, 1976a).

Material was therefore collected which described the:

1. Inter- and intra-professional role relationships amongst health centre staff;
2. Inter- and intra-personal relationships;
3. Patterns of communication;
4. Patterns of referral;
5. The mechanisms that provide for the legitimate expression of conflict between group members; and
6. The mechanisms that were employed to resolve conflict.

A central aim of the study was to gain an understanding of the

knowledge, perceptions and attitudes that respondents had of their contact with the local social work departments, or, in the case of social workers, the health centres; the nature of social worker-client transactions; the role and skills of the attached social worker; and their views on the attachment of a social worker to the health centre setting.

2. Participant Observation

The principal technique used to gather information about the way the attachment progressed, or the process of attachment, was participant observation. As a result of the generosity of the participants it was possible to observe their actions and interactions as they met informally over coffee, in the hall-ways and the reception area. In addition I was able to attend the formal meetings which took place in both health centres including the Health Centre Management Committee Meetings, weekly business meetings, and various clinical meetings. I also observed the social worker's monthly consultation sessions with the executive grade officers. The main disadvantage of this research method is that it generates a diverse range of complex material which may be difficult to handle (Becker, 1970). In order to manage this problem a 'dramaturgic' approach to data collection was adopted. This approach places emphasis on the identification of issues which the participants define as important, issues which also lead groups of actors to come together. Having identified a key issue care was taken to observe who participated in the discussions as well as those who were excluded. Details of each actor's view-point and negotiating position were also recorded. On the basis of this material it was possible to describe the interaction which took place and allowed a statement on the outcome of their decisions to be made.

From Observation to Participant Observation

McCall and Simmons (1969) and Smith (1975) show that there are a variety of roles which can be adopted by the participant observer which can be useful for gaining certain types of information, for getting into and out of specific situations, and for talking to certain groups of people. As a newcomer to the centre my initial role was that of interested observer, or participant-as-observer. During the first six to eight weeks in the centres much of my time was spent gaining a picture of where people were located and how they organised their day, discovering where decisions were made, who was party to the decision-making process and who talked with whom. On the basis of this information it was possible to chart the boundaries of the organisation and order my times and locations in the field as well as gain some idea of the potential logistical and methodological problems that were likely to arise.

A typical day might start (on a Monday morning) in Health Centre A with my arrival for the debriefing session when those who had been 'on-call' over the weekend reported back to their colleagues on the weekend's events. Following the meeting there was usually enough time to have a coffee and a quick chat with the subjects or arrange a convenient time to carry out an interview. Lunch was spent attending meetings or chatting informally with staff in the staff lounge or in the nurses' room. Interviews were usually scheduled from the afternoon. Each evening was spent transcribing the day's fieldnotes on to index cards. These cards were headed with the day and date, the setting, the names of the parties involved in the inter-action and the subject or focus of the inter-action. This system of recording made the retrieval

of the data, by subject or issue, easier and more accessible. In addition it allowed me to build up a picture of an important or significant event as it unfolded over time. Theoretical notes and theoretical inferences were recorded in red and methodological notes, logged ideas, suggestions and problems and were recorded in blue. This initial period in the field was a time when I became known to the subjects and they to me. As I became known to the health centre staff I became a more active participant observer. Indeed, at certain points in time I seemed to spend more time participating than observing. My participation took a variety of forms. On two occasions I actively helped the physicians to carry out two research projects, one related to problem drinkers (Buchan et al, 1981) and another study which examined the characteristics of attenders and non-attenders at a voluntary coronary prevention clinic (Wrench and Irvine, 1984). In addition I participated in a number of training exercises which involved trainee general practitioners and clinical psychology students. I also found myself acting as a source of information and material for the attached social worker on a variety of subjects to do with social work practice. In this way it was possible to establish and maintain stable relationships in the two health centres (Zelditch, 1961).

The descriptions of the different roles of the participant observer also indicate the phases in the researcher's relationship with his subjects. These have been described by Jones (1961) as; newcomer, provisional acceptance, categorical acceptance, personal acceptance and immanent migrant. Smith (1975) observes that this last phase may be critical as the subjects may become anxious over the researcher's impressions and findings. The problems associated with the final phase,

before the withdrawal of the researcher, were mitigated by returning to the settings after the fieldwork was completed.

As the first draft of the chapters of the study were completed the researcher returned to the health centres and a report was given of the findings. This allowed the participants to comment on the accuracy of the description as well as acting as a useful additional source of material.

3. Enumeration

For the study of the referrals made by the participants to the attached social worker a more quantitative approach to data collection was employed. For three enumeration periods of two months' duration each, the attached social worker was asked to complete a standardised patient referral form for every referral that she received. The form was divided into two parts and covered such details as:

1. Date of referral;
2. Source of referral;
3. Unit of referral;
4. Socio-demographic characteristics of the patient(s);
5. Method of communication; (referral agent-social worker).

The second part of the form dealt with the qualitative aspect of the referral and included questions about:

1. The social worker's interpretation of why the referral had been made;
2. The problem she identified at her first interview with the

client;

3. Her action in response to the problems identified.

These data were supplemented by a formal interview with the social worker and the referral agent. With respect to the social worker, the interview provided the social worker with the opportunity to expand and clarify her written statement. With respect to the referral agents, the interviews gathered important information about their:

1. Reason(s) for referring the patient; and
2. Expectations of the social worker's role.

Each referral was followed up for a period of up to eight weeks or until the case was closed by the social worker, whichever came first, and the referral agents interviewed in order to determine:

3. Their knowledge of what the attached worker had done; and
4. Their satisfaction with the outcome of the social worker's intervention.

On the basis of this material it was possible to examine whether or not the participants became more knowledgeable about the professional role of the attached social worker and, if so, to assess whether or not such changes were sufficient to bring about change in their referral behaviour. This material was also of value in order to describe referral behaviour and diagnostic decision-making. The picture that emerges however, remains incomplete as we were unable to observe the encounters between the professional staff and the patient. However, it is hoped that this omission has not detracted from its value.

4. Documentary Evidence

Finally, the patients's medical records were examined in order to check whether or not the social worker had made entries into the record and to carry out a content analysis of her entries. In addition I had access to; the agenda and minutes of the health centre management meetings; the agenda of the health centre--social work meetings; and various memoranda circulated within the health centres.

Recording

With the exception of the referral part of the study, which used a pro-forma, the principal means of recording the interview data and the field notes was hand-written while the interview, discussion or observation was going on. This was supplemented with tape-recorded material after the encounter had taken place. Every effort was made to use the respondent's own words, verbatim recording, which caught the respondents' use of words and their catchphrases. Effectively everything the respondent said was recorded. The evenings were spent writing up a full account of the day's material with the view to providing a picture of what the respondents said and how they said it.

Assessing Motives and Intentions

The description and interpretation of the motives and intentions which underpin the social actor's behaviour forms a significant part of this study. In the first instance a semi-structured interview schedule was used to tap the informant's motives (wants) and intentions (acts which the individual knows or believes can be expected to produce a particular outcome) in relation to the attachment programme. This is

legitimate. As Giddens (1976) observes, motives are accessible to the awareness of the actor:

not in the sense that he can formulate theoretically how he does what he does, but in the sense that given he is not dissimilating, his testimony as to purpose and reasons for his conduct is the most important, if not necessarily conclusive, source of evidence about it. (page 85)

Nevertheless, there are a number of methodological problems which arise when one attempts to get behind the individual's performance in order to explore their motives and intentions. This is particularly true when one is looking at the nature of power relationships.

Firstly, as Giddens points out, while social actors may be aware of some of their wants (or the grounds for their behaviour) there are occasions when their behaviour is influenced by sources not accessible to their consciousness. In his discussion of interests, Giddens points out that;

men are not necessarily aware of their motives for acting in a particular way, they are not necessarily aware of what, in any given situation, their interests are. (page 86)

Later, he writes;

to enquire into someone's motives for acting as he does is potentially to seek elements of his conduct of which he himself might not be fully aware. (page 116)

Thus people simply might not be aware of their preferences or intentions or they might not be able to articulate why they act as they do.

Secondly, the individual actor might attempt to conceal their 'real' motives and intentions from the observer. This is especially salient in studies which focus on power relationships where power holders may consciously conceal their motives and intentions from the power subject as in the case of manipulation or fraud (Lukes, 1974).

Thirdly, motives and intentions tend not to be unified constructs but rather a complex mixture of duty, concern, status seeking and utilitarian self-interest.

As a result of these constraints the question is posed as to how one produces a picture of the actor's motives and intentions which is capable of generating descriptions which are relevant to the analysis of power relations and capable of being transformed into useful categories of sociological discourse. In the present investigation these problems, as far as possible, have been dealt with by drawing upon a variety of different sources of data.

Firstly, I recorded informal conversations with the participants after an observed event had taken place. It appeared that while many of the participants found it difficult to respond to questions which addressed their motives and intentions in the abstract at one moment in time, their consciousness was awakened after they carried out an act to which a particular motive refers. For example, when the attached social worker's behaviour was judged by her erstwhile colleagues to be 'unacceptable' or 'not what they expected', even though they might have been unable at the start of the programme to specify 'acceptable' behaviour, such conflict stimulated the informants to think more clearly

about what they had wanted or intended with respect to the social worker's behaviour.

Another source of data which helped fill some of the gaps in data stemmed from my own experience in the research setting. Earlier in this chapter I discussed how I became immersed in the two settings, not in the sense of becoming a part of it but by being able to participate in it. This allowed me to gain access to the participants' motives and intentions as rapport was established. In effect, the researcher threads his or her way among his or her informants in order to win their confidence and admittance to areas of thought and action not generally seen in public.

This is not to argue that one obtains a different answer from the informant from that which one receives in normal interaction. Nor is the answer necessarily a more truthful one. Rather, these specially constituted circumstances allow one to supplement the material gained when one confronts the social actor with his or her behaviour in everyday life.

It is hoped that this mode of operation has gone some way to mitigate, as far as possible, some of the difficulties associated with this type of analysis and offsets to some degree the gaps in data collection which might have otherwise occurred.

The Limits of Case Study Analysis

This is an exploratory study which attempts to assess the relevance of accounts of medical dominance, derived from Freidson and others, from hospital settings to general medical practice. In addition it has the

aim of generating possibly interesting and useful sociological constructs relevant to our understanding of power relations within complex medical settings. Given that this is a case study questions about the validity and reliability of the findings might be prompted.

As with any piece of research, whether qualitative or quantitative, the charge can be levelled that the collection, analysis and reporting of data is 'subjective' and prone to researcher bias (selectivity bias), prejudice and error. There are, however, a number of techniques which have been employed in this study to offset any possible charge of partiality on the part of the researcher.

Firstly, as I have mentioned elsewhere in this chapter, a number of different techniques have been used to cross-check the various findings and observations; structured material was, for example, backed up by informal interviews with the informants and analysis of medical records.

Secondly, in this and the following chapter the methodological ground rules and the theoretical assumptions and principles upon which this study is based are spelled out. From this it is hoped that the reader will have the opportunity to assess for himself or herself the quality of the data and the analysis which follows. The reader may feel that the investigation requires a monumental act of good faith (Fletcher, 1974) that the material is accurate and can be trusted. Such doubts are, I hope, at least partially allayed by assessing my description of the methods for collecting, analysing and presenting the data.

Moreover, doubts about the veracity of the material presented herein are, I hope, mitigated by the fact that the researcher returned

to the research settings at the report stage and presented the evidence in such a way that the participants were able to judge the accuracy and quality of the study for themselves (this approach also acted as a useful secondary source of data). I returned to the centres on three occasions in order to deliver papers which raised specific points with the participants. The points which were raised included; the informants' views of the health centre-social work relationship, their views of the attachment programme and their evaluation of the programme's relative success. In addition the health service personnel and the social workers received copies of a draft report which summarised the results of the investigation. The response of the participants to this feedback has been incorporated in Chapters 2, 3, 4 and 9.

Questions may also arise as to how representative the study is. If it is agreed that the study presents a useful and accurate picture of the experience of one social worker in what are admittedly unusual medical settings the question remains how far do the results and analysis portray the experiences of other workers, who were not studied, in other settings. In other words, is it possible to move from the particular to the universal? In a statistical sense the answer is no. Where possible, however, I have attempted to broaden the perspective by drawing upon a wide range of descriptive studies which indicate when the participants in this study encountered similar sets of problems to those working in other settings and that they acted in very similar ways.

Closely related to the question of how representative the findings are is the question of how far one can generalise, at a theoretical

level, from these findings. I have attempted to deal with this problem by offering the theoretical accounts of other researchers who have studied the behaviour (thought and action) of actors in other medical settings and counterposed these to my own analysis.

Ultimately it is hoped that the study will be accepted for its strategic rather than the representative value of the case it describes (Freidson, 1975, pg 274). It is hoped the study will contribute in some way to the generation of theoretical statements which have wider application than the local general practice settings upon which this study of power is based.

The Plan of the Thesis

The investigation of the attachment of a social worker from a point seven weeks before she took up her appointment to her seventeenth month of practice afforded the researcher the opportunity to witness a new member attempt to establish a place within a medical domain and her attempt to gain control of her work situation and create the role she plays there. The first chapter of this study reviews the literature and analyses some of the explanations that medical sociologists have put forward to account for the division of labour in health organisations.

In chapter Two I examine the respondents' attitudes and ideas about each other and their relationship in the past and in the present. An effort is made to place the respondents in a broad occupational and structural context. This acts as a backdrop against which the social worker is placed. This is followed in chapter Three by a description of the participants' attitude toward and views of the attachment scheme. Chapter Four is concerned with their knowledge and expectations of

social work and the role of the attached social worker. These chapters identify the preferred outcomes that each individual worker and occupational group had of the attachment and the role of the attached social worker before she took up her post. Here I focus upon explicit conflicts in their definition of the situation and the objectives of the attachment scheme. Conflict is here defined as a situation when two or more actors are seeking to attain incompatible objectives.

Chapters Five, Six and Seven outline certain aspects of the social worker's experience of working within the health centre setting. In chapter Five I describe the nature, pattern and process of referrals to the social worker over three enumeration periods of two months' duration each. The following chapter looks at some of the issues and difficulties that confronted the social worker during her first fourteen months of practice and I describe the methods, or strategies she employed in order to gain control over and accomplish her work. Chapter Seven examines the attached worker's relationship with the area team.

In the final section I assess the extent to which the various individuals and occupational groups achieve their preferred outcomes. Chapter Eight deals with the extent to which the attached worker's definition of her role within the health centre matched those of her health centre colleagues. In addition I look at the extent of change in the health centre participants' knowledge and understanding of social work practice. This is followed in chapter Nine by an examination of the social work-health centre relationship and the participants' evaluation of the relative success of the attachment scheme in satisfying their largely political interests.

The thesis concludes with a chapter which seeks to lay out a framework for conceptualising the division of labour in general medical practice and describes the nature of power, influence relations between health centre workers and the role that negotiation has to play in the social organisation of health centre practice. I suggest that the outcome of conflict over objectives and the extent to which the participants achieve their preferred outcomes will be a function, among other things, of the power and influence of the participating parties. It is therefore argued that the division of labour and social interaction amongst organisational actors involves an extremely intricate pattern of power-plays, influence, inducement and persuasion.

CHAPTER ONE

INTER-OCCUPATIONAL RELATIONSHIPS AND THE DIVISION OF LABOUR IN GENERAL MEDICAL PRACTICE

In a collection of articles on health and the division of labour the editors make the observation in a foreword to one of the papers that while much interest has been shown by sociologists in the sociology of the hospital, general medical practice has largely been ignored (Stacey and Reid, 1977, p.87). Indeed, one quickly forms the impression when examining the reviews of the literature to do with general practice (Royal College of General Practitioners, 1970; Hicks, 1976) that the field has been left very much to the practitioners themselves, their representatives and spokespersons, and various government departments. Of course, this is not to say that all sociologists have neglected general practice as either a base from which to conduct research into patient care, or as a subject in its own right. However, as Horobin and McIntosh (1977), in an introduction to their study on GP responsibility, point out, research in this area of medical practice tends to be of a particular 'type':

"In general, both the 'medical' and the sociological studies provide detailed information on more or less specific illnesses or aspects of practice and, simply because they are specific and detailed cannot answer questions about the ways in which GPs organise their work".
(p.89)

Certainly studies of the 'type' alluded to by Horobin and McIntosh are of interest and value for the light that they shed on particular facets of practice in this setting. However, they tend to be of somewhat limited theoretical value insofar as they give the researcher or analyst little idea of the direction in which theoretical work ought

to be moving. Further, sociologists writing about general practice frequently fail to articulate their assumptions and theories on which their sociological formulations depend. As a result of these constraints sociologists surveying the British medical scene have often found it necessary to draw upon ideas, findings and theories developed in another social context, notably the United States (Goldie, 1977). This is no less true of the present study.

This situation, however, may be changing as it appears from the publication lists of journals and publishing houses that sociologists are beginning to take a more active interest in, and apply sociological approaches to, the analysis of general practice, particularly amongst those who may be defined as sociological phenomenologists or ethnomethodologists. Indeed, such is the interest shown in this approach to the study of all things medical that it may represent a new 'orthodoxy' in the sociological analysis of medical institutions.

While not wishing to deny the contribution that this approach has made to our understanding of medical practice and the social organisation of medical care and the many useful insights that have been derived from research based on this approach, I begin my review of the literature, as others have before me, with a description of the work carried out by Elliot Freidson. I will then go on to consider the various challenges that have been launched against Freidson's approach, particularly in regard to his concept of 'medical dominance'. I conclude with a description of the perspectives and assumptions which underpin the approach to the study.

1. Medical Dominance

Freidson(1973) suggests that there are two modes of organising labour and defining the task, who is to perform it and the way it is performed: the first is through bureaucratisation and the second is through professionalisation. Professionalisation can be differentiated from other modes of organisation on the basis that the division of labour is formed by the occupation itself, by the men who actually do the work. Thus, according to Freidson (1970, 1971) the way to bring theoretical coherence to the sociology of occupations and medical institutions is for the analyst to adopt as his central problem the organisation of control over work and the effect of occupational control on the work, the work force and the organisation (Freidson, 1977). The monopoly of the professional organisation over that which it defines as its domain and the authority of the professionalised occupation to control that which falls within its jurisdiction is, according to Freidson, of central analytical importance as a criterion for the differentiation of labour within medical institutions (1970, 1972, 1973a, 1977).

Such control presupposes a successful political organisation which is able and equipped to carry out negotiations with the state in order to establish favourable 'jurisdictions' in the organised division of labour. Such jurisdictions, or spheres of influence and control, can be established in a variety of ways, the most formal and effective means of gaining such control is through exclusive licensure (Freidson, 1970; 1972; 1973). By such means the 'jurisdiction' of the professional organisation is established and the boundaries drawn around the

institutionalised tasks over which the professional organisation has the authority to control. The state therefore acts to grant recognition to the professional organisation's monopoly over the service it provides and legitimises the professional dominance that the profession has within the institution (Freidson, 1970a; 1972; 1973; 1977).

Thus:

the professional has gained a status which protects him more than any other expert from outside scrutiny and criticism and which grants him extraordinary autonomy in controlling both the definition of the problems he works on and the way he performs his work. (Freidson, 1972, P.337)

The strategy of professionalisation, when it is successful, results in a system of occupational self-government which confers upon the profession not simply the right to define and determine the parameters and nature of its work but, in addition, allows the dominant profession to control the labour market. This is accomplished by means of the profession's authority to govern entry to the occupation through the control of education and training (Freidson, 1970a). Thus, in the case of medicine, the profession has been able to determine how many physicians are trained, how they are to be trained, and who is licensed to work.

Medicine, argues Freidson (1970a, 1972), is the most successful occupational group, amongst others, to have harnessed the professional mode of organisation. It has achieved and maintained its dominant position in the occupational hierarchy by claiming to have an exclusive body of socially valued knowledge and expertise. Indeed, medicine, he argues, is alone among the traditional professions of law, the clergy

and so on to have systematically increased its power by systematically drawing upon and linking scientific and technical knowledge.

Professionalisation of the organisation expedites the growth of a hierarchical structure of occupational relations based upon what Freidson calls 'the authority of institutionalised expertise'. As a result the dominant profession stands in a completely different structural relationship to the division of labour than does a subordinate occupation. On the basis of the organisational structure it has helped to create, and its monopoly and jurisdiction over the medical domain and all matters to do with health and illness, medicine is vested with the authority to give orders to a wide variety of subordinate occupations, even when the workers are the employees of other organisational structures. That is, it has the authority to supervise, direct and coordinate the work of subordinate occupations. This gives rise to a structure in which the division of labour is organised around the dominant profession (Freidson, 1970). At the same time paraprofessional occupations such as nursing (Dingwall, 1977), clinical psychology (Goldie, 1977), pharmacy (Eaton and Webb, 1979) and social work (Butrym, 1968; Huntington, 1981) are bound into an occupationally subordinate position, despite their attempts to gain control of their work situation by means other than that of professionalisation eg the bureaucratisation of social work.

Freidson's ideas about the medical division of labour and particularly his concepts of 'medical autonomy' and 'medical dominance'

have exerted a considerable impact on the development of thinking in medical sociology and the sociology of the professions. In regard to the relationship between social worker and general practitioner Huntington (1981) and Dingwall (1977) use 'medical dominance' as a key concept to account for the conflicts that can and often do occur when the two occupational groups meet.

The Domination of Social Work in Medical Settings

Huntington enumerates the structural and cultural differences between the two occupational groups which are thought to act on the one hand as a resource upon which doctors can draw to maintain their dominant position in the occupational hierarchy and on the other hand which act as an obstacle to the development of collaboration and cooperation between the two occupational groups.

The structural variables which she points to include: demographic differences; the size of the occupation's membership; its sex composition; the class of origin of its labour force; their level of educational attainment; and the relative size and source of its income. The cultural components include: learned values; standards of practical knowledge and techniques; and the ways that each occupation relates to members of other occupations within and outside of the medical institution. Differences between the two occupational groups to do with their respective structures and cultures are viewed as determinates of inter-professional hostility and discord which can ultimately lead to overt conflict.

Medicine is a long established, large professional organisation that is dominated by members who are drawn from a well educated, predominantly small, upper class who command a high income and status.

In addition, doctors are seen to work in a sophisticated technological work setting and deal with a wide heterogenous clientele made up of patients from all classes.

In contrast, social work represents a relatively young occupation with a young membership, the majority of whom are women from a variety of different social class backgrounds with less educational attainment. Thus, according to Huntington:

The dominance of medicine in most health settings and particularly in hospitals and general practice enables it to facilitate or inhibit these occupations' (social work and nursing) access to the kind of work for which they have been trained. (p.17)

Huntington argues that the attitudes of the medical profession towards social work and its attempt to control social work are shaped and informed by these structural and cultural variables. When social work, and other subordinate occupations, attempt to define the situation or exert their 'needs', perhaps best defined as interests, over others, the medical profession cites the longevity of their profession, its collective experience and corpus of knowledge in an attempt to impose and legitimise its own definitions of the situation over that of social work.

These structural and cultural variables take on special significance when the conflict between the two occupations concerns jurisdiction, who is responsible for what service to which clientele. General practitioners are said to treat social work as one of its subordinate occupations by attempting to control the social worker's field of action. Moreover, social workers appear to Huntington and

others (Goldie, 1977; Dingwall, 1977) to accept their subordinate status to medical practitioners and to accede to their demands, thereby legitimising, through their actions, the status differentials between the two occupations. This, Huntington argues, reflects the dominant male-female culture in which the two occupations are imbedded and parallels the sexual division of labour within society at large. Citing the earlier work of Nacman (1975-76), she suggests:

Medical social work's failure to confront directly the greater power of medicine and its tendency to try to 'influence' rather than seek and use power more directly may well rise out of the differential socialisation of males and females. (p.22)

In their encounters with medicine, social workers tend to accommodate rather than confront and resist the normative expectations of medical practitioners. Thus in the field of general practice and the emergence of the concept of the 'primary care team', the GP's unchallenged status and authority is assumed and medical dominance assured.

For Huntington medical dominance is related to the broader social issues of power and politics in society, particularly sexual politics and the sexual division of labour. The organisation of medical practice is viewed by Huntington as the product of political contests played out at the macro-political level.

The 'primary care team' and the relationship between physicians, social workers and health visitors serves as a central focus of Dingwall's (1977) analysis of ideology and its relationship to the

division of labour in general practice. Before I examine Dingwall's work, I will digress for a moment to discuss the concept of the primary care team.

The concept arose as a result of pressure within and outside medicine to link in a purposeful fashion the activities of the GP with the independently organised health visiting, home nursing and midwifery service (Hicks, 1976; Dobson, 1971) and as a result of the expansion of medical knowledge which placed greater emphasis on the social and psychological state of the patient or the 'whole patient'. In order to accomplish his work, the practitioner was forced to consider working with the members of other occupational groups so that medicine, nursing and social work are effectively 'yoked' together.

Thus the Royal College of General Practitioners (1972) reporting on 'The Future General Practitioner - Learning and Teaching' defined the role of the general practitioner as:

The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting room or sometimes in the hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice, he will work in a team and delegate when necessary. His diagnoses will be composed in physical, psychological and social terms. He will

intervene educationally, preventively and therapeutically to promote his patients' health.

As might be expected from the previous discussion, as multi-disciplinary group practices became more numerous doctors claimed that they were the 'natural' leaders of the primary care team (Royal Commission on Medical Education, 1968). His role as team leader was argued along traditional lines, that the general medical practitioner had superior knowledge of the key factors of the clinical situation, that he had the ability to treat illness and coordinate the work of subordinate staff; and because of the belief in the physician's responsibility for the continuing care of the patients who are registered with him (Hicks, 1976; Horobin and McIntosh, 1977) cannot be accepted or assumed by any other worker.

In the face of such claims to autonomy and dominance Dingwall identifies and explicates some of the mechanisms which help shape the division of labour in general medical practice and the way in which social workers and health visitors attempt to gain control over their work. Dingwall conceptualises the problem as one of exclusion and one of inclusion. He defines the two concepts as follows:

The former relate to the problem of defending some bundle of tasks as establishing the unique character of the occupation and warranting its claim to a distinctive existence. The latter relate to the jostling for social esteem as occupational members attempt to assert relationships of superiority over some occupations and equality with others.
(p.85)

He argues that while at one time the process of organising and

administering the work of different occupations would have been achieved by appeals to 'professional dominance' such claims have, in recent years, lost their legitimacy. In its place the term 'team' and 'teamwork' has emerged in the rhetoric of the profession as a means of deciding the question of the division of labour. However, the concept implies a degree of social equality between the various participants, who would come to some ad hoc arrangement to organise the division of labour for service delivery. Such a condition is in Dingwall's view entirely problematic so long as members of the medical profession are involved.

If one of the parties linked together here is medicine, then the whole situation gets caught up in the claims to a special status, that of "profession" which equality would imply. (p.86)

Dingwall, like Huntington (1981) and others (Beales et al., 1976; Horobin and McIntosh, 1977) locate the problem in the structural and cultural characteristics of general medical practice. These include the doctor's status as independent contractor, who is accountable for certain specific tasks; the influence of the traditional hospital-based model of practice with its emphasis on a stratified hierarchy of authority; and the sex and class variations of the 'team' members. So profound and entrenched are the structural and cultural differences between the various occupational groups which comprise the 'primary care team', he is forced to conclude that the concept of the team poses little threat to the existing social order and the perceived legitimacy of professional privilege within the medical profession. While others may question the legitimacy of the medical professional's overt claim to 'professional dominance' and authority over matters to do with health and illness, Dingwall is in no doubt where the power is located in

primary care team relationships.

There are, it seems to me, a number of inherent difficulties in the model of medical practice put forward by Freidson, Huntington and Dingwall. Firstly, they seem to treat people as little more than the players of roles or the holders of positions in a largely pre-determined system of relations. Further they seem to suggest that there is a concentration of resources, historical, cultural and structural, that are at the disposal of medicine (eg sex, education and class) which the subordinate occupations lack. In effect the inequality of control over resources forms a central part of the unequal power relation between medicine and other occupational groups.

2. 'Medical Dominance' Challenged

While the concept of 'medical dominance' has gained currency in much of the writing in the sociology of the professions and the sociology of medical care, Freidson and those who have taken up part of his work or put forward derivations of his argument have not been without their critics. The question is frequently posed, implicitly and explicitly, by a number of analysts 'Just how powerful is the medical profession?' A number of writers have put forward the view that patient deference and subservience to the authority of the doctor is undergoing change as patients become more assertive (Haugh, 1976, 1978; Johnson, 1977; Mechanic, 1970; Gill and Horobin, 1972); that subordinate groups have begun to question the physician's leadership role (Elston, 1977; Dummock, 1977); and that the state has increasingly intervened in the affairs of the medical profession (Johnson, 1972; Alaszewski, 1977; Armstrong, 1976; Gill and Horobin, 1972).

Elston (1977) in particular has looked at the challenge to medical

autonomy within the hospital sector and argues that there is a change in the distribution of power within the hospital and a change in the power relationship between medicine and other subordinate occupational groups. She argues that the simple fact that the doctor's autonomy is being challenged at all by heretofore subordinate groups, 'indicates a shift in the balance of power, even if to date for the most part, the attacks have been resisted.' (p.27)

Such challenges have been made possible as a result of changes within and outside of medicine. Changes in the demographic structure of Britain towards an increasingly older population and changes in the pattern of morbidity and mortality away from predominantly acute infectious disease to problems associated with major degenerative diseases such as coronary and cerebrovascular disease and malignant disease; handicap and disability by congenital defects and pre-natal damage; and problems of a chronic and disabling social and psychological nature; Royal College of General Practitioners, 1976). Such changes have led some writers to ask questions about the knowledge and expertise of medicine to treat such problems (McKeown, 1971; Cochrane, 1972). In a climate where the effectiveness of various treatment regimes is questioned, the authority of the doctor based on the efficacy of his treatment interventions undermines the legitimacy of the doctor's claim to authority based on his or her 'institutionalised expertise'.

Changes in the internal structure of medicine may, according to Elston, have created the necessary conditions for heretofore subordinate occupations to exert greater control over their work, free from medical

interference. While Freidson argues that the increasingly complex division of labour in professional organisations does little to alter his basic argument of continuing 'medical dominance' in medical institutions, Elston and others (Stevens, 1966; Mechanic, 1974; Godber, 1975) argue that the growth of new specialities parallel to medicine have effectively eroded the power and autonomy of the medical profession. Subordinate occupations have been shown to question the physician's 'right', perhaps more accurately termed his authority, to control their work.

In addition the new occupational groups have staked equal if not greater claim to the necessary knowledge and expertise to deal with particular types of problem and carry out certain specialist tasks. As new specialities emerge and new areas of knowledge are developed, the physician, it is argued, cannot be said to have a monopoly over all relevant 'Medical' knowledge. If the substance of its knowledge and skill is known and performed by another occupational group, medicine, in Freidson's terms, cannot be said to be completely autonomous. In such a situation, medicine loses its legitimacy and justification for claiming its special status.

An analogous situation may be found in general practice and its relationship with social work. Although general practitioners have laid claim to the knowledge and ability to deal with the patient's social, psychological and emotional problems, such claims have been challenged by social workers who argue that they have the competence and expertise to work in this field. Indeed, the social workers' argument was ultimately supported by the Seeborn Report (1968) which led to legislation which supported their claim to expertise in the field of

social-psychological and social-emotional work. In situations like these the physician's 'authority to know' (Mukerji, 1976) is challenged and, at times, denied.

The rise of independent representative and administrative structures amongst para-professional groups is also identified by Elston as a source of threat to medical autonomy. The disengagement of social workers from secondary settings such as hospitals and psychiatric institutions and their incorporation within a personal social service bureaucracy is of special significance.

The Social Services Act (Scotland) 1968 and the Local Authority Social Services Act (1970) placed previously separate specialities, like medical social workers, mental health welfare workers, psychiatric social workers and welfare officers under a single department. Social work has effectively broken away from medicine in order to establish its own place in the division of labour parallel and unsubordinated to their erstwhile occupational superiors (Freidson, 1977, p.32). As a result, physicians have become increasingly dependent on autonomous groups of subordinate workers in order to run the hospital and to treat, in the case of general practice, 'the whole patient'. Similarly Webb (1975) argues that this had the effect of removing the GP from the centre of day to day working relationships in both an organisational and professional sense. The GP was no longer in a position nor had the authority to coordinate, control or commit the resources of occupations from other independent organisations. While recognising the medical profession's near monopoly over the handling of the sick and its power and authority to define, control and evaluate the work of subordinates,

both Elston and Webb argue that the superordinate position of the medical profession is far from secure.

Zola (1975) has described the tendency of medicine to expand its jurisdiction into new areas of practice, particularly those areas to do with man's social, emotional and psychological wellbeing. He defines this process as the 'medicalisation' of social life. Medicine does this by first laying claim to jurisdiction over the label 'illness', and anything to which it may be attached. Medicine then expands into the realm of the social world by; redefining what is deemed relevant to the good practice of medicine; maintaining absolute control over certain technical procedures; maintaining absolute control over certain 'taboo' areas; and expanding what medicine deems relevant to the quality of human life.

Thus it is no longer necessary for the patient merely to divulge the symptoms of his body, but also the symptoms of daily living, his habits and worries. (Zola, 1975, p.176).

Yet medicine particularly at the level of general practice, has not been alone in seeking to extend its jurisdiction and attempting to expand that which falls within its domain. Social work, using a different set of strategies, has been engaged, with some success, in a similar process.

Burchell (1981) in his exposition on the way in which social work has expanded into new fields of practice describes the process as one of 'infiltration' or 'seepage' along lines opened up across administrative and professional territory by other social welfare and health organisations. He cites as an example the way in which social work has

become central to practice to do with the family and child care.

From here it establishes new connections, extends already existing ones, installs points of interchange and forms new patterns for the operations of social agencies. (Burchell, 1981, p.74).

Thus the growth of social work, as an occupation in terms of both its size and its independence has posed a threat to both general practitioners (Huntington, 1981) and health visitors (Dingwall, 1977, 1983) and may be regarded as a competitor for control over a grey area of territory which is ill defined and poorly institutionalised (Smith, 1981).

Finally through unionisation, professionalisation and, in the case of nurses, managerialisation (Carpenter, 1977) associate professions have been able to gain greater control over their work by taking control over the entry to the occupation and the education of its new members. This too is seen as a challenge to the right of doctors to be the arbiter of all aspects of health care. (Satyamurti, 1981; Whittington, 1983).

The Decline in Medical Authority: A Critique

The analysis of medicine's dominance within medical institutions by Elston and others is a valuable contribution to the study of the division of labour in medical settings as it forces us to reconsider the nature and strength of medicine's power and its ability to control the medical setting. However, there are a number of issues that arise from her argument that must be taken into any consideration of medical dominance and the division of labour.

Firstly, Elston appears to regard the relationship between occupations in regard to their autonomy, power and control over the work situation as a zero-sum formula. That is, she assumes the gains in autonomy and control made by one, emergent, group of subordinates is at the expense of the superordinate profession of medicine. This assumes that the total rewards that are distributed among the various parties are, in some way, fixed. However, other writers, among them Freidson (1979, 1973, 1977) and Eaton and Webb (1979), have argued, albeit implicitly, that the situation within medical institutions can best be described as a varying sum game in which one occupation's gain may not be the other occupation's loss. Freidson (1977) appears to have anticipated Elston's remarks when he states:

Trade unionism, I would guess, will succeed in improving the terms and conditions of work, but will be unlikely to change their position as workers whose work is ultimately at the disposition of others. (p.25).

He goes on to remark:

In present-day health care, a professionalised industry in which the division of labour has grown increasingly complex, for fifty years or more, there is little or no evidence that physicians have been losing significant elements of their monopoly over ordering and supervising the work provided by other occupations in the division of labour. Interdependence does not necessarily corrode dominance. (my emphasis). (p.28).

These observations have been partially borne out by Eaton and Webb (1979) in their study of the relationship between pharmacy and medicine. They argue that while paraprofessional groups may extend their

boundaries into the medical domain, the medical profession may willingly delegate or relinquish control over certain tasks to other professional groups, a process that the authors define as 'demedicalisation'. This does not in their view represent a direct challenge to the physician's authority as a certain 'trade off' is made, whereby the subordinate group:

accept the ultimate responsibility of the medical practitioner for his patient in exchange for the right to practise certain 'medical' activities on the periphery of clinical medicine. (Eaton and Webb, p.85).

Like Johnson (1972) and Freidson (1973, 1977) they argue that such arrangements do not ultimately challenge the autonomy or authority of medical practitioners.

There is nevertheless an extensive body of research literature which draws attention to the fact that power relations are never totally unilateral and therefore almost always involve an element of influence by the subordinate over the superior (Cook et al, 1983; Sarason et al, 1978; Emerson, 1972). Indeed some suggest that lower status organisational members both in medical and industrial organisations wield a great deal of power within the organisation (Mechanic, 1962; Clozier, 1969; Burns and Stalker, 1961; Smith, 1979; Irvine, 1979). For example, subordinate workers may refuse to accept the instructions of their superiors; they may have specialist knowledge about the organisation and the way it works that their superiors do not have; and they have access to information which their superiors are unable readily to obtain. Thus, the ability of subordinates to distort 'commands' and 'use the system' and to influence physicians for their own benefit is

something that has to be taken into account in any discussion of power relations and the division of labour. What is of salience here is the question, not that some groups have power and others do not, but rather that in spite of a considerable degree of power the subordinate occupations possess they may choose, as in the case of Eaton and Webb's pharmacists and Goldie's social workers and clinical psychologists, not to exercise their power or resist the control of their medical superiors.

Elston's argument is weakened further by virtue of the fact that she focuses almost exclusively on the physician's autonomy to control the work setting. Bound up in this concept of autonomy are the related concepts of power, influence and authority which are neither defined nor fully explored. She therefore places emphasis on challenges to the doctor's authority to control, based upon the source of the command and his perceived status, resources and personal attributes of the superordinate profession. This is seen in the way she explores the challenges to medicine's claim to knowledge of the field of health care. This focuses upon two particular types of authority; challenges to the physician's competent authority and challenges to the physician's legitimate authority to direct and control the work of others (Weber, 1968; Wrong, 1969) or in Freidson's terms 'the authority of the expert'. Competent authority refers to those relationships characterised by the subordinate group obeying the commands of the authority out of the belief in the authority's superior competence or expertise (Wrong, 1979, p.53). Legitimate authority, like Weber's ideal type of legal-rational authority, rests on the formal position of the superior in the hierarchy of authority within the institution and shared

within a large group or community. This approach fails to take into account different types of power and authority relationships. For example, it ignores those situations in which the compliance of the subordinate may take place out of fear. Elston fails to consider the possibility that the authority relationship between superordinate physician and subordinate worker may be based explicitly or implicitly on coercion (coercive authority). Bendix (1962), cited in Wrong (1979) notes:

as a realist in the analysis of power he would be critical of any translation that tended to obscure the 'threat of force' in all relations between 'superiors and subordinate'. (p.37).

Thus while there may be challenges to the doctor's legitimate and competent authority to control the work of others, they may still command deference because subordinates fear sanctions being applied, eg in the case of Goldie's psychologists and social workers, fear of losing particular types of referral.

Elston also fails to take into account two other matters salient to an understanding of relations between medical and paramedical and lay workers in the medical setting and the division of labour within medical institutions. Firstly, as I suggested above, one of the advantages of being a powerholder is that they are able, in the last resort, to tap alternative forms of power should existing methods of control, like claims to their competent authority or clinical accountability, be tried and fail. Wrong, for example, argues:

It is to the advantage of the powerholder confronting a heterogenous and differentiated aggregate of power subjects

(both individuals and groups as we would find in the hospital or a multi-disciplinary general practice) to be capable of exercising multiple forms of power to control them. (p.73).

Jamous and Peloille (1970), Parry and Parry (1975) and Atkinson (1977) have observed, the history of medicine is one of adjustment and resistance to perceived threats to its autonomy and 'clinical' freedom. (1) Thus, the medical profession has, in the past, been able to perpetuate its superior position in the medical hierarchy by adopting new strategies and tactics of resistance (an example of this would be the threats by GPs, following the setting up of the National Health Service, to resign from the service if certain government policies were implemented (Dopson, 1971; Eckstein, 1959; Honigsbaum, 1979). Given the recognised success of the medical profession to maintain and protect its privileged position, one would expect physicians, individually and collectively, to adopt alternative strategies of control, such as persuasion and coercion, to maintain their positions. As Mechanic (1974) argues:

It is inevitable that if physicians should become too threatened, they will use whatever power and influence they have to thwart change or to subvert change once it occurs.

Another central problem for those who, like Freidson and Elston, focus upon the physicians' authority to control medical settings and those who work therein is, as a number of ethnographic accounts on specific aspects of medical practice have shown, that the deference and compliance shown to the doctor by para-medical workers and the laity is not simply accorded to the doctor by virtue of his position within the

medical hierarchy. Rather doctors have been observed to continuously 'work' at maintaining their autonomy in the face of challenges from patients, their relatives and other para-professional staff (Bloor, 1976; West, 1976).

Nevertheless I agree with Elston to the extent that I believe medical dominance has been challenged in certain areas of practice and organisation. That is, it can be argued that attempts are made by superordinate occupations to gain control over certain specific work situations and certain practice territories, as illustrated by social work's claim to deal with psycho-social and socio-emotional problems. It should be added that this represents a particularly grey area of practice which a number of different competing groups, including GPs, nurses (Anderson and Hasler, 1979) and clinical psychologists (Koch, 1979; Goldie, 1977) have laid claim. Thus, while both medicine and other occupational groups may claim to have jurisdiction over a particular piece of occupational territory, even when such territories are salient to the identity of the particular occupations, as in the case of social work, none of the occupational groups can feel particularly secure that a given area of practice will remain under their jurisdiction and within its domain. (2)

The point that I am trying to make here is that if we treat the division of labour and the distribution of power within medical settings as exclusively hierarchical and unilateral we will miss various relations between occupational groups in which the control of one situation by one group is counter balanced by the ability of the other group to control the other in a different situation. That is, the question is posed whether or not the authority and power of the

physician, which they bring into their encounters with subordinate groups, is generalised across different sorts of situations. There is, after all, no a priori reason to suppose that the power of medicine cuts across all decision-making areas salient to medical practice. The vertical, hierarchical dimension of power is important in understanding social life within medical settings, but it is not the only dimension of power (Perrow, 1970).

Jouvenel (1958) in an interesting essay on authority relationships identified three variable attributes of all power and authority relations. In it he suggests that there are three dimensions which, taken into consideration, facilitate a comparison between different types of power relations and structures. The dimensions that Jouvenel identifies include:

1. Extensiveness; the number of subjects (B) under the influence of the superior (A);
2. Comprehensiveness; the variety and number of situations or domains in which (A) controls the activities of (B); and
3. Intensiveness; the extent to which (A) can push (B) without a loss of compliance from (B).

In effect Jouvenel highlights the importance of giving any concept of power, like that of negotiation 'direction' in the context of a situation in which power plays are carried out. It is therefore desirable to seek out an approach or model of the relations within general practice which highlights the complexity of the issue of occupational control and the division of labour. Such an approach may be found in the studies of a psychiatric hospital by Strauss et al

(1964) and others (Bucher and Stelling, 1969; Ehrlich and Sabshun, 1964; Shatzman and Strauss, 1963; Goldie, 1977; who have developed from the symbolic interactionist perspective, the concept of the 'negotiated order'.

What I am arguing here is that all three of Jouvenel's dimensions can usefully describe the scope of power. One of these, comprehensiveness, subsumes the distinction made by what some writers call the issue specific and cross-issue specific dimensions of power.

The Negotiated Order of Medical Institutions

This approach seems particularly well suited for the study of those organisations and associations which appear to be rather loosely organised and where there is much ferment and change in terms of treatment ideologies and social organisation, such as general medical practice. Strauss et al (1964) argue that the social structure of psychiatric institutions is one that is in a constant state of flux. Internal differentiation and segmentation proceeds, on a daily basis, as a direct result of the negotiation, bargaining and coalition formation and disintegration between organisational actors. The social structure of psychiatric institutions is, therefore, regarded as a product of human or intellectual construction whereby the organisational actors, through their interpretative activities in the social world, produce and reproduce the structure.

Practically, we maintain, no-one knows what the hospital 'is' on any given day unless he has a comprehensive grasp of the combination of rules, policies, agreements, understandings, pacts, contracts, and other working arrangements that currently obtain. In a pragmatic sense, that combination 'is' the hospital at the moment, its social order. (Strauss et al 1969, p.312).

Strauss and his colleagues therefore regard medical organisations as man-made constructs of human endeavour. Thus they conceive of the hospital setting as an 'arena' in which treatment ideologies are clarified, modified, transformed and put into operation and where occupations jockey with each other in pursuit of their own interests and in attempt to gain control over their work situation.

For Strauss et al (op cite):

Though the physician may be captain of the medical team, the nature of his captaincy - even when it is accepted - is changing rapidly.

Therefore:

One cannot understand what is happening in and to hospitals without an informed systematic focus upon them as locales for the pursuit of professional purposes. (p.377).

The medical institution is transformed into a setting in which 'power-plays', 'politicking', 'persuasion', 'bargaining' and 'negotiation' is the 'rule'. Even the norms and rules which structure social relations by guiding, directing and legitimising behaviour are, according to Strauss, 'negotiable'.

The realm of rules could then be usefully pictured as a tiny island of structured stability around which swirl and beat a vast ocean of negotiations. But we would push the metaphor further and assert what is already implicit in our discussion: that there is only vast ocean. The rules themselves are negotiable. (p.313).

They conclude that "there is a 'negotiated order' within which rules fall". Power to make rules and control behaviour is not therefore thought to be located in specific positions, rather, it is reduced to a

matter of inter-personal influence diffused throughout the organisation and where the balance of power shifts in response to different issues and as different groups and individuals move through the system.

As a result of these forces, the division of labour and occupational relations will take different forms from institution to institution and within a single institution's departments. Thus it is possible to find many instances where the medical monopoly and control is effectively breached by other equally influential occupational groups. This approach has been found attractive to a number of authors who have attempted to apply it to the British psychiatric scene. The model proposed by Strauss has, however, been found wanting when it is applied to other concrete settings.

The Negotiated-imposed Order of the Psychiatric Hospital

In a study of the relationships between psychiatrists, social workers and clinical psychologists Goldie (1977) argues that Strauss et al neglect the prior domination of the division of labour by certain groups, psychiatrists, and the power that these groups exert over the organisation. He finds that Strauss's approach fails to fully explicate how objective differences in the power and autonomy of certain groups can exist with the concomitant lack of subjective awareness amongst subordinate groups of their domination. Secondly he questions the nature of the autonomy enjoyed or denied specific occupational groups within the medical institution. Unlike Strauss et al he does not presuppose that the parties who engage in a process of negotiation are relatively equal, and that power is equally distributed throughout the institution. In order to account for these phenomena he focuses upon

the role that ideology has to play in the process by which superior groups gain and maintain control over their work situation and the way in which the social actors perceive and interpret the social structure of the institution.

He also argues that the nature of the catchment area, the resources and facilities that are available within and outside of the hospital, the demand on the hospital's material and human resources, and the legal responsibility of the doctor for certain strategic tasks, have an impact on authority relations. In effect these variables act as a skeletal structural framework within which negotiation takes place. Therefore, the power, influence and autonomy of the occupational sub-system of the institution is bounded by the constraints existent within a structural supra-system. This supra-system of structure, restricts the amount of room different groups of actors have to manoeuvre in their attempt to gain control over their work. In contrast to Strauss, the social structure of the institution remains, for Goldie, a most formidable and comprehensive constraint in individual and group actions (Lukes, 1977).

Goldie views the power relations in psychiatric institutions as essentially asymmetric. Additionally and unlike Strauss, he shows how psychiatrists exercise a high degree of control over the actions and behaviour of the subordinate social worker and clinical psychologist. Nevertheless, despite the structurally dominant position of the physician in the authority hierarchy of the hospital he is able to detect a certain amount of reciprocity of influence between the various parties.

Unlike the dominance theorists, Goldie begins to show us the way

actors define their situation, and how their actions, intentions and motivations form part of a dialectic with the institutions in which they work. He found in his interviews with staff members that certain groups of social workers and psychologists appeared generally unaware of their subordinate position. Indeed certain groups of workers actively reinforced the authority of the psychiatrist by defining themselves out of certain situations and by engaging in marginal activities. He is, therefore forced to conclude that:

While the division of labour may have been imposed by psychiatrists, it continues to be maintained by the very staff who occupy an inferior position within it. (p.159).

Taking Goldie's argument about consciousness and power relations and structures to its logical conclusion, one could argue that the distribution of power in any medical setting in favour of anyone but the power elite remains nothing more than a figment of the imagination until such time as the subordinates become aware of their power and influence. Like Dimmock (1977), he argues that those occupying an inferior position may exercise control over their work situation only when they are aware of the power context in which they work and aware of their own power to exercise control over the actions of their superiors.

The work by Goldie is of importance to the present study for a number of reasons. Firstly, he demonstrates the extent to which the negotiation of social roles, of central concern to this study, takes place within a framework of material and other givens where certain things, like the doctor's right to prescribe medicine, are non-negotiable. Thus, not all of the participants to the interaction are conferred with equal power to define their own and the significant

others' situations. Secondly, the study again shows how individuals and occupational groups will resort to various methods, tactics, and strategies to secure professional status in the absence of power and authority. This is achieved to a limited extent through various forms of accommodation to the powerful occupation. Thirdly, Goldie takes a positive step in the direction of developing a perspective of the medical institution which enables him to make a connection between macro-sociological and historical process on the one hand and individual biographies on the other.

Goldie leaves us however with a number of outstanding questions to be addressed. For example 'what is the structure of the negotiations which take place within medical settings like general practice?' - 'who negotiates with whom over what issues?' and 'what are the constraints to negotiation?' In summary, we need to know a good deal more about the process of negotiation, what is the direction of the negotiation; what are the preferred outcomes of the respective parties to the negotiation; and how successful are they at achieving their preferred outcomes; what methods, tactics and strategies do the actors adopt to achieve or resist that which is being negotiated; what is the content of the negotiations - who sets the problem to be negotiated, what do they consider the problem to be and why?

In other words, we need to give the concept of the negotiated order direction, and place such negotiations within the confines of the existing social structure of general medical practice. It is these questions that the present study hopes to address.

SUMMARY

The writings of sociologists on general practice reflect a wide range of substantive interests and theoretical orientations. Recently more attention is being paid to examining the socio-political context of medical work. In particular, sociologists have focussed their attention on the way in which doctors, medical workers, non-medical workers and patients interact in a variety of settings and the way in which the medical division of labour is accomplished.

Various arguments have been put forward which suggest that the division of labour in medical practice is shaped by and around a dominant profession, medicine. Alternatively, there are those who argue that changes inside and outside medicine have resulted in a bid for control in the setting by subordinate medical and non-medical groups who challenge the traditional authority and the autonomy of the medical profession. In response, the dominance theorists argue that despite challenges to medical autonomy, their power in medical settings remains virtually intact and the work of subordinate occupations remains firmly under medical control.

There have been a number of studies of psychiatric institutions which adopt an entirely different approach to the study of the medical division of labour. Based upon an interactionist perspective the writers assume that people, all people, exercise a certain degree of mutual influence and control over one another's behaviour in all social interaction. The social actors are, therefore, thought to engage in a process of negotiation which results in the construction of an inter-subjective structure of medical relations and a negotiated division of labour which is context bound and time limited.

Later adherents to this model have criticised this approach implicitly and explicitly on the grounds that it assumes that all of the parties to the negotiation are conferred with relatively equal power and that the social structure is nothing more than the sum total of the actors' subjective meanings and interpretations. Rather, they argue that the negotiations that take place have an impact on the social organisation and division of labour of the institution, but these negotiations are bounded by a given structure.

3. DISCUSSION - PRINCIPLES AND ASSUMPTIONS

The study of the social work attachment scheme hopes to cast some light on the inter-occupational relations and the division of labour within general medical practice. It focuses upon the everyday relationships between general medical practitioners, para-medical and lay staff. In it I will examine the workers' definition of their situation and the way in which the participants of different, often rival, occupations attempt to gain control over certain aspects of their work situation, seek autonomy of their own affairs and prevent the encroachment of other workers into what they define as their domain in the relatively unstable and uncertain environment of general practice. In short, I am concerned with the micro-politics, the way in which power is developed and used (or 'power in action'), of health centre practice and the 'realpolitik' of inter-occupational relationships amongst health centre workers.

It is understood that the concept of power is extremely problematical (Lukes, 1977; Dahl, 1957; March, 1966; Pfeffer, 1981). As Weber (1968) observed:

the concept of power is sociologically
amorphous. All conceivable qualities of a

person and all conceivable combinatin of circumstances may place him (the social actor) in a position to impose his will in a given situation. (p.54).

The concept of power extends through a wide range of writings about the social organisation of medical institutions. As I have noted early in this chapter, a central weakness of many of the studies that I have reviewed is that they offer no clear definition of what is meant by 'power' and 'authority', in all its various forms, 'dominance' and 'control'. Indeed it would appear that in some cases the writers treat the terms as synonymous. March (1966) has argued that in being used to explain many things the concept of power has become almost a tautology, utilised to explain that which cannot be explained by other ideas and incapable of being disproved. Indeed, some writers have questioned the utility of the concept of power because of the lack of precision of its meaning (Dahl, 1957).⁽³⁾

Dahl (1957) defines power as a relation among social actors in which social actor A can get another actor B to do something that B would not otherwise have done. Power, therefore, is thought to have a coercive element which has sufficient force to change the pattern and probability of B's behaviour from what it might have been in the absence of actor A. A similar definition of power is put forward by Emerson (1962) who states; 'The power of actor A over actor B is the amount of resistance on the part of B which can be potentially overcome by A'.(p.32). Those who adopt this definition of power to explain the inter-occupational relationships amongst medical and non-medical staff define power as a process by which the dominant group, physicians, is able to determine and intentionally affect the behaviour of the other

subordinate group (Tannenbaum, 1968). This may be represented as A directing and controlling B's attitude and behaviour against B's better judgement and interest. This is achieved by virtue of A's dominant position in the hierarchy of authority. The problem of this definition is that it tends to blur the distinction between power, influence and normative constraint as Strauss, Goldie and others have shown. That is, it ignores the situation in which A is able to influence B's attitude and behaviour by changing B's mind in a process of negotiation. It is, therefore, necessary to draw a distinction between influence and negotiating power.

While power may be difficult to define, it is not necessarily difficult to pinpoint. Power, for the purposes of this study, will be treated as a subcategory of influence and is defined as the capacity of some organisational actors to produce intended and foreseen effects on others (Lasswell and Kaplan, 1950; Wrong, 1979; Pfeffer, 1981; Selancik and Pfeffer, 1977; Allen, 1979) in order to get something accomplished; to expand the power already possessed; or to extend the situations in which power can be exercised. Negotiating power refers to those relationships where the actor B retains his objectives but loses out to A whose objectives prevail. A can be said to have negotiating power as observed in his ability to obtain the outcomes he prefers when he is faced with competing outcomes in the negotiating situation.

It follows that when attempts to exercise power in the relationship with actor B are unsuccessful, when the desired outcome is not reached, we may say that we are confronted with a situation in which actor A has no power, or that there has been a failure of power-play in the sense that B has successfully resisted A even though A may have been

successful in the past.

Influence, on the other hand, refers to the situations in which actor B changes his objectives because actor A influences him to do so. The ability of A to modify B's preferred outcomes and objectives in the negotiating situation is treated as an example of A's influence over B. It is understood that power and influence will interact in complex ways. Further, it is necessary to keep in mind that the institutional control of others, through power or influence, is likely to result in certain unintended consequences.

Following Strauss et al (1964) and others, notably Goldie (1977), the study treats the health centre as an 'arena' in which actors compete, negotiate and bargain in an attempt to control their field of work, to protect jurisdictions and achieve their preferred outcomes in the decision making process within a given social structure.

Negotiation, for the purpose of this study, is defined as a process whereby two or more actors, or groups of actors, attempt to settle what each will give, take, perform or receive in a transaction. Following Goldie this action is thought to take place within certain situational and structural givens which act as constraints to the parties entering into negotiations and which limit the strategies and tactics they adopt and bound the issues which they are able to participate in. This perspective is therefore broader than that adopted by Strauss in that I am concerned to look beyond the immediate situation to examine the response of actors in a structural context of physical and social resources which the actors may or may not perceive. An attempt is made to identify these structural constraints and to determine the extent to

which they limit the freedom of certain individual actors to bargain, eg the impact of role expectations held by other actors of the social worker's role; expectations which are legitimated or taken for granted. However, this is not to say that what the actors say and do is determined by structural, objective relationships alone.

The study also departs from Strauss's original approach in that it does not depict the actors as free and equal participants together negotiating and constructing a mutually acceptable definition of organisational reality. Rather, the actors are viewed as coming to their encounters with each other with varying degrees and resources of power and influence. I will attempt, therefore, to seek an explanation for the participants' relationship to each other in terms of their command and use of power resources, their position within the organisation and their allegiance to certain belief systems and values. Aside from examining the determinants of negotiation, I will also focus upon the consequences of negotiating, or bargaining, power, and link negotiating power to the use of particular types of tactics and outcomes.

As Freidson and others (Dingwall, Goldie) have shown, not all organisational matters are open for negotiation, for example, the physician's responsibility to write prescriptions. What is and what is not open to bargaining or negotiation is itself related to power. The study will therefore examine the range of situations which are perceived by the actors to be open to negotiation.

Unlike the approach to the study of inter-occupational relationships and the division of labour of medical institutions

advocated by Strauss, it focuses almost exclusively upon conflict. According to Strauss, to focus upon such interactions, conflict between the negotiating parties, is to misconstrue the significance of negotiation.

interaction should not be visualised as arising mainly from conflict among negotiating parties. To construe negotiation so simply is to miss its great significance. Structural theorists tend to see negotiation, when they see it at all, mainly in conflict terms, as stemming from incomplete adherence to norms or from the breakdown of mutual understandings and expectations. (p.376).

There are a number of advantages to adopting a conflict model for the study of medical organisations.

Strauss and others show that the experience of organisational actors and those who study medical organisations is one that exhibits a flourishing political life. Differing objectives due to differences in opinion, differing interests and positions within the organisation and the endemic presence of bounded rationality make medical organisations, and organisations in general (Crozier, 1964; Burns and Stalker, 1961) an arena of political conflict characterised by intentional acts of influence to protect the interests of individuals and groups (Allen, 1979; p.77). In a situation of conflict between two or more actors, power and influence are two forces which help resolve, or partially resolve, the differences between competing actors and outcomes (Lukes, 1977; Pfeffer, 1981). That is, the underlying power relationship becomes more apparent, or visible, in conflict situations.

In addition, conflict over certain decisions and issues highlights

the power relationship. Wrong (1979) and Pfeffer (1981) observe that power is a characteristic of social relations among social actors. Pfeffer wrote (p.3) "A person is not 'powerful or powerless' in general but only with respect to other social actors in a specific social relationship." The focus on decision-issues shifts the basis of the conceptualisation of power and influence away from inter-personal, inter-group or inter-organisational control, toward control over decisions. By doing so I hope to avoid the implication that power and influence are an attribute of the actor or collectivity of actors so as to emphasise the relational properties of power between different groups.

Moreover, writers such as Freidson and Huntington implicitly assume that the dominance of the medical profession is not related to a limited set of decision issues but is generalisable across a wide range of decisions in the medical setting. The question of how generalisable the power of physicians is will be treated in this thesis as an empirical question and not as a matter of definition. I will therefore attempt to assess the circumstances in which power is generalisable across decision issues and in what cases the power and influence of the social actor is more issue specific.

I will in the first instance detail certain issues connected with the attachment programme which the participants regard as salient to the programme and specify their preferred outcomes, for, it is argued, it is in regard to preferences and the values and beliefs implicit in their preferences that conflicts of interest emerge (March, 1978).⁽⁴⁾ I then identify a set of disputed issues, the individuals involved and the actual outcome of the dispute. By adopting this strategy I hope to

obtain a relative estimate of the negotiating power of the actors in this setting.

The study of the occupational politics within the health centre is seen as a struggle for power and autonomy by some organisational actors and the struggle to resist and escape from the power of others while enhancing their own autonomy within the relationship. It is hoped that a better understanding of the lower level processes on the subjects here and now will contribute to a better understanding of the social organisation of general practice in a particular setting, operating in a given social and material environment.

CHAPTER TWO

THE HEALTH CENTRES AND THE AREA TEAM: CONFLICT OR CONSENSUS?

This chapter of the study is concerned with the participants' perception of the social work--medicine relationship. According to executive officers from the regional social work department, one of the underlying reasons, or goals, for setting up the attachment programme was to bring about change in the attitudes toward and perceptions of social work held by members of the health professions in a positive, although unspecified, direction. Two of the major research questions set for the pre-attachment interviews were (i) how do the actors perceive the social work--health centre relationship and (ii) why do they perceive their relationship in the way that they do? This approach was based on the assumption that, for the most part, the participants' subjective orientations toward each other were formed in the context of their routine everyday encounters. I appreciate, however, that this represents something of an over-simplification: for example as a result of their hospital commitments the doctors made frequent and regular contact with social workers in the hospital setting and in the community e.g. through adoption panels, community oriented psychiatric work and the like.

Attitudes toward Social Work amongst Health Service Workers

Unlike the findings from previous studies of health service workers' attitudes toward social work (Harwin et al, 1970; Ratoff et al, 1974; Dingwall, 1977) the health workers' comments suggested that they had a positive attitude towards social work and maintained a positive interest in working with social workers. Indeed, the majority of the

participants felt that social workers provided, or could potentially provide, a useful, and necessary, service to the patient population while making an important contribution to the development of the primary care team. With the active support of the medical personnel, both health centres had, at one time, played host to a number of social workers from the area team who provided an informal liaison service. In addition, the health centres provided a venue for regularly scheduled meetings designed to bring representatives from the area team together with medical personnel, although these meetings had fallen into abeyance in Health Centre B.

Despite the relatively high level of support for social work and social workers in general, the participants were highly critical of their relationship with the area team and its staff. All of the doctors and para-medical workers were of the opinion that many of the advances that had been made by members of both groups of workers in bringing the two services together had been reversed during the previous year. This deterioration of inter-professional relations was attributed to various situational factors, e.g. high staff turnover and structural factors associated with the organisation of the area team. What emerged as the major source of dissatisfaction, particularly amongst the doctors, was one particular feature of the administrative system of the team associated with the allocation of clients to individual social workers.

The local social work department had, at one time, been organised on a 'patch' system whereby an individual, identifiable, social worker was responsible for the pool of clients and potential clients residing in a specific geographic area in the New Town. This arrangement was similar in form to the system used by the various health centres in the

area whereby each centre drew the majority of its patients from specific districts in the town. The patch system had been replaced, however, by a system of allocation based on the concept of short-term and long-term teams. This change in administrative organisation had been made, according to senior social work staff, in response to pressures from the community on the area team's limited human and material resources.

From the point of view of the medical staff, who were either unaware or unprepared to accept the underlying rationale for this change, the new system was unduly complex, time consuming and inhibited the development of consistent inter-professional working relations between medical staff and individual social workers at the grass roots level. That is, from the point of view of the health centre workers, as a result of the change from a 'patch' to a 'team' system of service delivery they no longer had a regular workable relationship with an individual social worker.

The Health Centres and the Area Team

All of the health centre staff who participated in the interview were critical of their relationship with the area team. Only the occupational therapists and the 'liaison' social workers were exempt from what amounted to a blanket criticism of the local social work department:

Sister Dollar: "I usually go to the O.T., it's really a good relationship; good liaison and she's good at supplying aids. Also we can discuss cases with the O.T. We assess the case, refer the patient to the O.T. and she follows it up and refers back to us. She even asks us if we're happy with the aids provided! Sadly, we might lose her".

Nurse Henry: "Contact with Mary (liaison social worker) was very

satisfactory. She was the one who originally made the effort to come over here to meet me. She always kept me informed so I felt that I wanted to keep her informed."

Such praise did not extend to the area team as a whole. Unlike the doctors, however, only two respondents, the community psychiatric nurse Mr Miller and Nurse Art, a health visitor, made direct reference to changes in the system of client allocation and service delivery in the area team as a primary source of inter-professional tension.

Mr Miller: "They swapped to the patch system and suddenly it was two or three social workers that dealt with the (New Town) area - it had a negative effect on both sides. If anyone wanted to contact the social worker they had to 'phone the department. That meant the duty officer and they wouldn't know the case and its details. It became very difficult. You wonder who to relate to, since the advent of the new allocation system you don't know who to relate to".

While their reluctance to accept change in the organisation of the area team may indicate the doctors' and related health service workers' preference for a system with which they were familiar, their comments suggested that the erosion of confidence stemmed from more specific differences associated with the structure and methods of work adopted by the health and welfare systems. The main areas of tension highlighted in the interviews consisted of:

- (i) the area team's use of short-term and long-term teams for the allocation of work and the delivery of service to the client population and the impact it had on professional and personal relations;
- (ii) the length of time the social workers required to decide whether or not to allocate a patient;
- (iii) the area team's use of a 'priority system' to rationalise the

provision of human and material resources, and;

- (iv) feed-back from the area team about patient/clients held in common.

In addition:-

- (v) a number of the participants found it difficult to accept the social workers' definition of their role and remit; and
- (vi) some were critical of the quality of inter-personal relations.

The remainder of this section will examine these various critical areas in more detail.

1. The Short-term and Long-term team

For the majority of the participants working in the two health centres, the local department's change from a patch to a 'team' system for allocating work had resulted in a deterioration of relations between the medical and social services. More specifically, they felt that as a result of this arrangement communication with the area team had become problematic.

Dr Gold: "In the old days we always had one or two social workers who would come to the health centre and who knew the problems ... the problems of our patients and our own professional problems ... This was abandoned for a 'pooling system'. Now we don't have the structure to communicate regularly with the social workers".

Dr Ivory: "We were not happy with the way they abandoned the patch system. We feel that the liaison has become very poor as a result of that. There's no single person to contact. For all I know the social workers may be seeing patients on my list and I'm not aware of it and vice versa. They seem remote and communication has become very difficult". (Speaker's emphasis)

Dr Craig: "It's changed (the allocation system). Before we had individual, personal discussion with the social worker serving our area. Now it's become a 'team'

approach; now it's become a suspicious approach. The problem is that the collective responsibility is not as great as a single person's responsibility".

A second feature of the area team's structure which found little favour with the health centre workers was the position of the duty social worker. This strategic position was filled on a rota basis by members of the short-term team. While they described their contact with the duty social worker as amicable, they nevertheless found the regular changes in the occupancy of this position counter-productive to the development of close working relations between the two services; a problem which had, perhaps, become more acute with the change from the patch system.

Dr Deans: "They're friendly but it's difficult sometimes referring things through the duty social worker; it's rather irritating. There are so many different people that it's difficult to keep up with them ... The problem is not having a defined person who you know, and who you can contact, who knows your patients. There's a real need for a duty social worker who is familiar to the the various professions in the area".

Dr Hall: "The problem (with contacting the duty social worker) is that you get a different social worker every time you call the area office. You never know who you're dealing with".

Nurse Curry: "When you 'phone you find that you can't get in touch with the social worker involved in the case or with your family. They're always at meetings".

For the para-medical workers the trouble stemmed from the fact that the social workers and medical staff organised their working day around different routines. That is, both groups of workers spent a great deal of time visiting families in their homes and were therefore not always available for contact.

Sister Dollar: "Once I've made contact with them I might not get them again for weeks and I'm left in the dark as to what has happened. But, obviously, they have their caseloads to follow up as well. If they're busy, out in the morning, they may try to take a message. Then they 'phone you back and you're out, or you 'phone and you find that it's engaged".

The participants conveyed the impression that they placed great emphasis on having a single, identifiable social worker whom they could firstly contact, and secondly with whom they could develop a personal, long-term relationship. They therefore agreed that changes in the administrative structure of the social work department were causally linked to the decline in the quality of inter-professional working relations between themselves and the social workers. (1)

In part their attitude toward and perception of organisational change was formed by their experience of the patch system. Several respondents made unfavourable comparisons between the 'way things had been in the past' and their relationship with the area team at the time of the interviews. Thus, their criticism of the new system of allocation may reflect a tendency on the part of health service workers to support systems of organisation which were known and understood by them, particularly if such systems were similar to those they employed for service delivery. There is also, of course, a tendency to idealise the past. However, this does not explain why they placed such overriding importance on having a known, identifiable, social worker with whom they could develop a close personal relationship.

In part, the answer to this question lies in the organisation and structure of general practice and particularly the relationship between the doctor and his patient. According to the Royal College of General

Practitioners (1972), the general practitioner is, ideally, responsible for the "personal, primary continuing care to individuals and families". Further, he is held personally accountable for the treatment he provides to the patient and the treatment that others, such as health visitors and practice nurses, provide under his instruction or on his behalf. (2)

When faced with an alternative system based on the concept of a team approach to decision-making, particularly at the level of deciding who, if anyone, would take responsibility for a particular referral, the doctor defined the system as diffuse, overly complex and totally foreign to his own methods of work.

Further, in those instances where a basic grade social worker was involved in a given case, the practitioners felt, in the course of their transactions with the worker, that they were dealing with the 'real' decision-maker, the basic grade worker's senior social worker, second-hand, through a third party.

Dr Gold: "Some (basic grade) social workers rely on their seniors to take decisions for them. The social worker is then berated for failing to do what I thought they should do. In one case the social worker hummed and hawed and it was the senior that was taking decisions for him".

Such views are likely to be confirmed and reinforced in relation to certain types of cases. For example, cases which involve cash payments to clients, e.g. Section 12 payments, will, as a matter of social work practice, be transferred by the basic grade worker to someone higher in authority for a final decision. Similar perceptions are also likely to emerge in instances where information is passed on to the doctor by an intermediary, or spokesperson, for the worker actively involved in a

case, e.g. by a senior social worker, duty officer, etc. Such encounters were regarded as less intense and less satisfactory than a direct encounter with the relevant social worker.

Dr Lamb: "If I speak with the one (social worker) directly involved in the case, they have the knowledge about the case. It's when you deal with a case second-hand or when they pass messages through someone else that it's unsatisfactory".

Sister Dollar: "Sometimes they send a representative (to the health centre/social work meetings) or someone passes on a message to you. It isn't satisfactory because he won't be clued up on the whole thing".

The participants also regard the system used to process the patient through the social work agency and the 'client careers' of their patients in the department, as unsatisfactory. The patient who is referred from the health centre, or advised by the health centre worker, to seek out social work services, will first come in contact with the duty social worker who will make an initial assessment of the presenting problem. On the basis of this assessment the case may be disposed of in a variety of different ways. In some instances the individual seeking social work services may be advised to contact another agency, e.g. in the case of financial problems the individual may be encouraged to contact the Citizen's Advice Bureau. In the case of straightforward social problems the case may be dealt with by the duty social worker. In other instances, however, the case may be put forward for further discussion at a weekly meeting of the intake team. At this stage in the client's career the decision will be taken to put the case up for allocation to either the in-take (short-term) team or the long-term team. Depending on the problem certain cases will, as a matter of

course, be transferred to the long-term team for allocation, e.g. cases involving probationary after-care, care and supervision of the mentally handicapped, etc.

The main points I would like to make regarding this process are: (i) that cases are not always allocated to members of the team; such decisions are left to the discretion of the individual workers and their willingness to extend their caseload and (ii) once a client has been allocated it does not necessarily follow that the case will be dealt with by the same worker until the problem has been resolved and the case closed. It is possible that in certain circumstances clients may be transferred from one team to another, usually from the short-term to the long-term team. In other circumstances, notably when a member of staff is leaving the area, the social worker's caseload will be reviewed with certain cases ear-marked for planned closure and others put up for re-allocation to another member of the team, again a process dependent on the discretion of the remaining workers and their willingness to take up the case. In contrast to the straightforward system of patients registering with individual doctors this process of allocation is seen as complex and time consuming, particularly by the general practitioner. Further, it represents a structural barrier to the development of personal, continuous relations between the health and social service workers which was highly valued by the individual general practitioners and para-medical workers. It is also likely that the doctor will contrast this process with the idealised model of his own relationship with the patient and his position as the provider of medical skills, services and decision-making at the primary care level. In short, the process and structure of allocation will be regarded as antithetical to

the interests and needs of the patient/client and the health centre worker.

2. Timetables

The participants found it difficult to reconcile their desire for immediate action by social workers in response to a health centre referral with the area team's process of case allocation.

Len Ratoff (1974) in a perceptive article on the problems of doctors and social workers working together, noted the differences between the two groups in the amount of time each required to arrive at a 'diagnosis' of the problem presented by either the patient or the client. Physicians and other para-medical workers who were accustomed to making quick decisions regarding the diagnosis and treatment of patients were contrasted with social workers who were seen to engage in a laborious and time consuming process extending in some cases over several months. These differences in 'clinical' timetables stems from the differences between doctors and social workers in technical expertise, the type of problems that each group of workers encounter and the nature of the task set for the two professions. The physician's emphasis on 'doing' relates to his training in hospital, when delay may result in the death of the patient (Freidson, 1972) and the applied character of clinical work.

This clinical frame of reference gives rise to what he calls a 'special frame of mind' oriented toward action of its own sake, action based on 'radical pragmatism' (p.239). Indeed, as Cochrane (1972) has observed, even though many established medical techniques are of dubious, and at times unproven, effectiveness, the dangers of non-

treatment and non-diagnosis are seen as greater dangers than the dangers of over-treatment and over-diagnosis. Doctors are, therefore, trained for the most part in intervention; negligence is of more concern than iatrogenesis (Cochrane, 1972; Illich, 1975, 1977; Zola, 1970).

This is in contrast to social work theory and practice which regards hasty intervention and action as poor social work practice (Pincus and Minahan 1973; Specht and Vickery, 1977; Davies, 1981). The risk for social workers is to act too quickly (Huntington, 1981). This belief leads social workers to delay taking action rather than to take action before a 'relationship' has been formed with the client and all the 'facts' are known.

Further, the apparent value that social workers place on developing an understanding of the client's personality militates against the development of a rapid decision--response system of service delivery. Thus, Marshall and Hargreaves (1979) in an article addressed to social workers interested in attached posts, warn:

The speed with which doctors, and to some extent nurses, work is in stark contrast to the laborious social work process with an emphasis on self determination and the person in his social context. Social work can offer no simple 'treatment' and seldom anticipates 'cure'. This different approach and pace can be intensely frustrating for doctors and nurses ... (p.76).

The doctor making clinical assessments and management decisions within the six minutes of a surgery consultation can be contrasted with, for example, 'short term' case workers who could require anything from a few minutes to three months to define and 'treat' a given case. These

differences in the timetables of social workers and physicians act as a constant source of frustration between medicine and social work (Rosengren and Lefton, 1970).

A number of doctors expressed just such frustration with regard to the area team social workers.

Dr Craig: "It seems to me that they often act to delay making decisions more than anything else. It would be better if they just said that they can't do anything with a problem family rather than putting it off from week to week 'to see what happens'. It's a delaying tactic more than anything else".

The primary source of frustration amongst the participants centred not on the differences in 'clinical' timetables and the decision-making process but rather on the length of time social workers require to decide whether or not a referred patient would be formally allocated to a caseworker.

Dr Hall: "I can't pick up the 'phone and say to them personally 'I'd like you to see this case for me' and have them take it up. On the other hand, if they call me then in all likelihood I'll have to see the patient. The social workers have to discuss it at an allocation meeting presented by the duty social worker. We then have to wait for them to decide whether or not they may or may not take the case on. Rather than deal with the indecision and the uncertainty, we try to make do ourselves".

The comments made by one health visitor sum up the general sense of frustration experienced by all of the attached health workers:

Nurse Innes: "It's got to the stage where we don't 'phone up (the Social Work Department), it's easier to just get on with it ourselves. I do accept that I have a 17 year old unmarried Mum who wants to start adoption proceedings and that I can't do anything

about that. They promised to allocate her at the first meeting, that was three meetings ago and they still haven't done anything about it. The baby is due in three months' time. They don't seem to have the same sense of timing as we do, with anything; batterings, neglected children, etc." (Speaker's emphasis).

Whilst all of the staff were aware that the social work department was, at the time of the first interview, understaffed and experiencing some difficulty dealing with the volume of work passing through the department, this understanding did little to mollify their sense of frustration with 'delays' in the allocation process.

Delays in decision-making were also interpreted by the centre workers as a waste of their own valuable professional time.

Sister Flowers: "They delay (making allocation decisions) and waste my time. It's a waste of my time when I have to wait to get something done or wait for a bit of information".

The majority, if not all, of the participants treated quick action as the hallmark of a 'caring' profession and 'good' professional practice.

Sister Edge: "It takes so long (for a decision to be made) and they're supposed to be caring. If a person needs help they need it today or tomorrow, not at the weekend or next week. 'We'll see to it at the weekend', that's what they've said to me and I don't mind telling you, I was very disillusioned with that".

Dr Ivory: "In general practice things are dealt with minute by minute, day by day, etc. We can't wait for weeks for someone to do something. We can't wait weeks for something to happen".

In response to administrative delays a number of physicians suggested that they pursued a variety of different patient management

strategies, other than referring cases to the social work department. These strategies included not delving into the patient's personal circumstances, attempting to deal with certain problems themselves and referral to attached staff, notably health visitors, community psychiatric nurses and the attached clinical psychologist. In a sense the doctors opted not to comply with the rules and regulations governing the procedure for case allocation within the area team. Indeed, these management strategies proved to be a source of additional frustration for certain practitioners. For the physician trained to believe that some form of treatment intervention is better than none at all and for those who defined their clinical responsibility in terms which included taking an interest in their patient's social and psychological state, the management policy of either doing nothing at all or at best, 'muddling through' was the source of much frustration and dissatisfaction: dissatisfaction and frustration attributed to the internal working arrangement of the area team.

Delays in the decision-making process were, moreover, interpreted by the allied health workers, explicitly and implicitly, as a challenge to their professional competence particularly their ability to identify, assess, diagnose and dispose of patients suffering from a variety of different complaints judged by the worker to be 'social problems'. One incident, which had become part of the 'history' of Health Centre B, illustrates this point. (2) The case, involving a young man dying of cancer, was referred to by the general practitioner, a health visitor and the community psychiatric nurse who commented:

Mr Miller: "The incident that really sparked things off was a patient dying from cancer. He was one of Dr

Nelson's patients. He and the health visitor asked the area team to assess the family and help by giving him money. What happened was that it had to go to an allocation committee and four weeks later we had a decision, by which time the guy had died. That created feelings. This man ...er family required the help of social workers urgently, you know, to make his life easier, but they just didn't seem to see it that way".

Similarly, health centre workers found it difficult to accept any delay in case allocation decision-making on the grounds that a problem, once identified, could quickly develop into a 'crisis' if immediate action was not forthcoming.

Mr Grant: "We make a referral and the case isn't dealt with by an individual social worker. By the time they do get involved and it's dealt with, it has reached crisis point".

It is of tangential interest that the health worker's concept of 'crisis' seemed to embody at least two meanings. Firstly, 'crisis' may refer to the objective socio-psychological state of the patient in response to a particularly traumatic situation or experience. Secondly, health centre staff used the term 'crisis' to refer to their own response to certain clinical situations: when the worker was faced with a problem which he was either unable to avoid or unable to deal with himself, the worker experienced a sense of growing, or impending, 'crisis', particularly when faced with delays in the area team.

3. Priorities

Both medical and social services practitioners are faced with the problems of rationalising the human and material resources made available in the patient/client population. In the course of their work general practitioners employ a variety of different strategies to

control their workload, e.g. the use of appointment systems, out of hours cover, referral to allied staff and the application of a variety of 'personal' strategies.

Decisions are also taken within the NHS to channel scarce resources from one sector of the medical system to another based on the concept of 'priorities'. (Hunter, 1979) Thus, depending on what is actually defined as a priority at a given point in time, the doctor may find that funds are being transferred from the hospital to primary care; from the acute services to services for the chronically ill; from administration to clinical practice. Nevertheless the area team's use of a 'priority list' to control their workload and channel their resources found little favour amongst health service workers who regarded its use with some suspicion.

Dr Deans: "I realise that they are understaffed and that allocation is difficult; that's another criticism of the regional authorities really. But when I make a referral I expect something to be done. I expect them to at least see the patient. But the social workers' allocations procedure makes it difficult, it gets tied up with their system of priorities". (Speaker's emphasis)

Another doctor cited a case in point:

Dr Nelson: "I had a man a year ago, a man of 32, dying of cancer, who was being nursed by his wife. They had one problem which I thought could have been dealt with quickly by the social workers; they had only one set of sheets for the bed. As the man became progressively worse, it became more and more difficult for the wife to get the sheets off the bed. When this happened she had to sit the man up in a chair and he'd have to wait while she washed them. This caused him a great deal of pain. I asked the social workers if they could do anything for them. I was told that they would need to consider it at a team meeting to see whether or not it was a priority".

The majority of practitioners regarded the very idea of priorities or rationing as antithetical to their notion of what constituted good practice.

Problems also arose as a result of a lack of convergence between the health workers' and the social workers' perception and definition of what constituted a priority (ideological conflict). Differences in the frames of reference employed by the two groups to make sense of the problems that they encountered and their tasks resulted in feelings of frustration, on the part of participants, which was translated into a pervasive sense of suspicion; suspicion that social workers were employing the priority list in order to evade the more mundane areas of work which they associated with social work practice. That is, a number of respondents were suspicious of social workers using the claim of 'priority' in order to generate caseloads that were more professionally and personally rewarding. Of particular importance were cases defined by the participants as 'financial problems'.

Dr Gold: "I do see it (the sorting out of financial problems) as part of their role. I do think that they should listen to and advise patients about financial matters. I don't think that this should be seen exclusively as their province, but it is part of their job that they shouldn't shirk".

The research findings partially supported their perception of the priority list and its function within the area team. For example, during a management meeting with the executive officers, ten months after the start of the attachment, the observation was made by the senior social worker from the area team that 'the attached social workers' priorities were different from the area team's'. This

observation provided the opportunity to carry out informal interviews with social workers which focussed on the concept of priorities as they applied to the local team.

It was of note that the attached social worker felt unable, or unwilling, either to define or clarify the priority list. Rather the suggestion was made that I address such questions to the senior staff in the area team. Follow-up interviews with senior staff also failed to reveal (i) what the content of the priority list was, and (ii) how it was applied on a day-to-day basis. Rather, it emerged from these interviews, that decisions to allocate cases were influenced less by the priority list and more by the willingness of individual social workers to extend their already considerable caseloads, their interest in a given problem and their ability to deal with particular types of problem. That is, the decision to accept or reject a referral was left, for the most part, to the discretion of the individual workers.

Similar findings have been reported in a recent government document (DHSS 1975) focussing on social work practice. The authors note:

12.8 ... we see that the task of managing caseloads or workloads in hospitals and area teams was regularly left to the social worker's personal decision. These decisions were rarely made as part of a general plan and were usually related to a given case rather than a system of priorities.

The authors go on to suggest:

Several (social workers) were quite aware of the drawbacks involved in leaving 'priority' decisions entirely to the discretion of individual workers and indicated that there were inherent

deficiencies. Reliance on the system alone unsupported by a structure in which all cases were periodically reviewed, could inadvertently result in some cases being overlooked which were unrewarding, unpopular, or not very vocal in their demands.

It is questionable whether health service workers would ever accept the concept of priority in these circumstances if this is what 'priority' meant in practice.

Firstly, it is of some importance to the practitioners that either cuts to or restrictions in the resources made available by the social services will almost inevitably mean a greater strain on the resources of the NHS in general and the general practitioner in particular.

Secondly, the application of the priorities list to patients referred by the health service worker was associated, in the minds of some practitioners, with a lack of concern on the part of social workers to the needs of the patient and the doctor, the health visitor, the community psychologist and so on.

Thirdly, the strict adherence of the social worker to a list of priorities also led to a feeling amongst the participants that the social workers were disinterested in negotiating a working relationship on a case by case basis and that social workers were excessively impersonal in their transactions with primary medical care personnel.

Fourthly, medical practice is characterised by the doctor following certain structured rules in the investigation, diagnosis and treatment of illness. Doctors apply these rules in a particularistic way, on a case by case basis (Berlant, 1975). Again, the use of an a priori list

priorities to select cases before a thorough investigation had taken place was regarded by the practitioners as too simplistic and inimical to 'good practice'. As one GP observed:

Dr Nelson: "I think that there is a certain danger in categorising priorities too early. And to say that it is a priority to deal with babies, or children, or bereavement is too simple".

Restrictions in social service provision also present the general practitioners and health visitors with something of a professional dilemma. General practitioners and health visitors have been encouraged to concern themselves with patients whose difficulties are as much social and psychological as they are physical. Further, in ideal circumstances, they are expected to refer to the appropriate agency those patients whom they feel unable or ill-equipped to treat themselves. When these resources are either under-financed or unavailable at the local level, this responsibility becomes problematic.

In addition the general practitioner works in a 'demand-lead' service, supplying treatment and care at the patient's request for medical advice and services (Hicks, 1976). This is in contrast to social work departments who provide 'supply-lead' services; making services available to the local population on the basis of the availability of human and material resources (Whittington 1983). The state also acts as a mediating agent between the social services and the public by defining who is to receive the service (Johnson, 1977). The doctors therefore characterised their work as essentially open-ended and found the restrictions in social services difficult to accept. This is of course, as I mentioned earlier, an idealised view of what doctors do. They do indeed offer more time and effort to cases they find

professionally interesting and professionally rewarding (Buchan and Richardson, 1973). Further, they use subtle and not so subtle methods of controlling their work - e.g. receptionist to screen patients and 'put patients off', appointment systems, and engaging in behaviour that makes it clear to the patient that the consultation is over. Nevertheless general practitioners do have to see everybody or, when this is not possible, make arrangements so that the patient can see another practitioner.

Dr Ivory: "One of our complaints is that we feel that we work in an open-ended service and it's annoying that they seem to use restrictive practices. By that I mean they work restrictive hours; they have a definite lunch break and they finish at ten to four on a Friday. Also they're pretty selective about what they take on. We find that pretty hard to swallow".

While I have no conclusive evidence to support the claim - at best there is only circumstantial evidence on this point - the doctors may have been jealous of the way in which social workers were able to select their caseload.

Para-medical and non-medical staff expressed views similar to those of the doctors regarding the social work department's use of a priority list to rationalise its work. During the course of the interviews each worker took the opportunity to cite an instance of a patient being turned away from the department because they were not regarded as a 'priority'. As one health visitor commented:

Nurse Henry: "I referred a single, pregnant girl who was very withdrawn. I discussed the case with Dr Hall and we decided that she needed help. They didn't think it was their problem but they said that they would see her on a duty basis. The girl made the effort to go to the office and the only thing the social

worker said to her was that she wouldn't be allocated".

Nursing staff in particular reacted strongly against the fact that the area team had posted a notice on their door directing prospective clients, with a range of non-practical problems, to the Citizens' Advice Bureau.

Nurse Innes: "We feel that they should have a role as financial advisers and be able to help more in that way. They don't seem to want to have anything to do with it. There's a notice on their door 'Housing and Financial Problems should go to Citizens' Advice'."

Like the doctors, they too consistently contrasted their open-ended work within the National Health Service with that of social work in the area team:

Nurse Innes: "They can say 'no, that's not something we deal with', and we can't. The idea of an allocation meeting doesn't go down well with me. It's a case of the social workers having the power and the health visitors having the interest".

This strategy for rationalising scarce social work resources was thought to have a number of important consequences for staff working in the health centre setting. Although some argued that social workers and, for example, health visitors each have a unique and distinctive role to play in the provision of services (DHSS, 1968), in practice their roles are subject to much confusion, overlap and 'role blurring' (DHSS, 1969; Goldberg and Neill, 1972; Hicks, 1976; Fry, 1976).

In the absence of good working relations with the area team all of the general practitioners commented that they tended to dispose of certain types of patient by either dealing with the problem(s)

themselves or by referring the patient to other members of the primary care team, notably the health visitors and the community psychiatric nurse. When this type of referral was made, the doctor held the expectation that the nurse would act as their 'social worker' to the best of their ability. Although health visitors did view themselves as 'front line social workers' in certain situations, they did not always agree with the doctors' general definition of their role. One of them commented:

Nurse Innes: "We should be doing our own work, dealing with kids and Mums. But, we feel as though we're having their role shoved on to us. It's easy for them to say 'we aren't going to do anything about this' regarding finances but we can't refuse to see a patient. So the patients immediately come here when they have no joy at the department. In some cases the patients come here first. We aren't trained social workers and we probably get things the wrong way around".

The refusal on the part of the social workers to take up certain referrals was felt to place an additional burden of work on the shoulders of the attached health centre staff.

Further, para-medical workers experienced a sense of professional isolation or a feeling of 'going it alone' which led some if not all of them to assume a defensive approach to practice, particularly in cases involving children thought to be 'at risk' of physical injury. Nurse Innes went on to say:

"I've referred 'at risk' children who are enclosed within 'at risk' families to the social worker. We're not carrying the can for anyone and if you looked in our records here you'll find that 'contacted the social worker' appears quite often".

The area team's use of a priority list to rationalise its work was,

therefore, a source of systemic and ideological conflict. The medical and non-medical health centre workers failed to obtain services on behalf of their patients because the patient's presenting problem, or the health worker's definition of the presenting problem, was not congruent with the social worker's practice ideology (Rees, 1978).

4. Feedback

An area of controversy frequently cited in the literature is the lack of feedback of information about the patient/client from the social worker to the medical worker once a referral has been made. (Bruce, 1980; Jenkins, 1978; Brooks, 1977; Coulstone and Jones, 1976). Although the participants praised the efforts of one or two individual social workers who 'kept them informed' about the client and his circumstances, they all complained that this did not occur as a matter of course.

Dr Fair: "Once they take on a case that's it. It's like a stone wall, there's no real attempt to up-date our information (about patient/clients). In the past cases that I've referred have been taken up and I didn't know why or on what grounds".

Dr Deans: "We don't get information from the social workers without a great deal of hassle. Even when it does happen, they're very selective about the information they do let us have ... I get cross when this happens. If a professional is a professional person, then he or she should realise that we are bound by the same ethics. I believe that we're all working for the common good of the patient".

Nurse Art: "I think we all feel that the information is one-way - from us to them. They seem to regard confidentiality as their top priority but they want us to give them information. It doesn't strike them that our needs are as great as theirs for information.

Like the GP's, the allied health workers expressed the opinion that the social workers did not communicate information in a routine fashion. Rather, information was passed on only under duress. And that the information they received tended to be an edited version of what was known to the social workers.

Nurse Innes: "We feel that we do all of the communicating. We supply them with information but they don't let us know what is in their files. We have to hassle them before we get feedback".

Nurse Brown: "I think that they give us what they think we should have. If there is anything really drastic going on in the family we can only hope that they would let us in on it. Sometimes we feel that they're being cagey".

Ms Grant: "One family was on everyone's books. They have a 16-year-old son who is having problems with the police. The problem was raised, at this end, and we asked such questions as 'when was the boy going to appear, in which court, etc.' This information was not passed on routinely. It tends to be us that asked the questions".

For others, however, contact and communication difficulties stemmed from the failure of social workers to respond to requests for information from the health centre.

Mr Miller: "The other problem is getting a hold of someone. These are for little things that don't require an outright referral - information, advice, that sort of thing. But still there is a three week delay and the answer to the question is not always forthcoming. You can ask the social worker to 'phone back later' and 'later' never comes".

Social workers, who are members of a young and emergent profession, may not be aware of the normative patterns of behaviour associated with the feedback of information within medical practice. Horobin and MacIntosh (1977) note:

Interprofessional relationships and courtesies are apparently better understood between the two older professions (medicine and nursing) but lead frequently to friction between those two and social workers". (p.95)

The feedback of information to referral agents has become increasingly important as a result of changes in the social organisation and social structure of primary care. General practice has, in the past decade, become highly complex and characterised by increased internal differentiation as new disciplines take up positions in the primary care team. The communication or feedback of information therefore becomes of paramount importance since the co-ordination and continuity of patient care depends on it.

Dr Gold: "We need contact and feedback so that we have co-operation rather than conflict in advice giving; where the advice that you give is consistent in the management of the family. This conflict does happen. I know from experience. Also a person being seen two or three times per week by different people could become confused; who is doing what, what they are there for and what advice they give".

Sister Flower: "You can have too many people involved without knowing what everyone is doing. Especially in my case - because I'm seeing people who are going into and coming out of hospital".

Many of the health centre staff expressed the wish not only to avoid where possible the replication of therapeutic work, but in addition the more mundane factors such as duplicating the time spent travelling to visit the patient/client at home and the time wasted on failed attempts to see the patient at home.

Nurse Curry: "Information is needed for the continuity of care between the social worker, the health visitor and the doctor, particularly where children are concerned. It's necessary to know what's going on and what people are doing sooner rather than later. Otherwise I'll end up having to go on another home visit, sometimes to see women who aren't particularly welcoming. If the social worker is going into the home and a social worker has been allocated the case, all I might need is feedback. And that's true for when I'm doing the home visits. Feedback, that's all we need".

For members of staff like health visitors and psychiatric nurses whose work routinely took them into the homes of the patient, and whose role was oriented toward 'case finding', the discovery that the patient was being seen by a social worker often came as an unpleasant surprise.

Sister Flower: "I don't feel that we do communicate. I've discovered many cases having a social work involvement which they (social workers) didn't tell us about. It's then that I find that they have their own catalogue of information and we have ours and that we don't use the information as best we could".

Indeed, such discoveries were often a source of embarrassment to the individual worker.

Nurse Henry: "Sometimes it's happened that I've gone in to see a patient and we'll be talking about this and that and the patient says 'ye ken that I'm seeing a social worker'. It's embarrassing, they seem to expect you to know what's been going on, who's involved, that sort of thing".

It is an obvious point that social workers are faced with a dilemma when asked to communicate information to other professionals about client/patient held in common, particularly in situations where the client/patient has asked that the information remain confidential. However, the health centre workers found the rhetoric of confidentiality

spurious when in their experience the social worker did impart details of a case when confronted by the health worker. For example, a health visitor described the case of a 21 month old baby whose mother was 'young and inadequate' and whose father was known to have a history of violent behaviour. The health visitor commented:

Nurse Henry: "I was really concerned about the cold. I called the area team (a) to let them know about the situation and (b) to ask them about a cooker and a heater. They told me then that they were well aware of the case and that he (the husband) had thrown a dog out of a top storey window. If he did that to a dog what would he do to a calor gas heater. So there had been quite a lot of social work involvement in the past. I thought thanks for letting me know".

5. Definitions of the Social Worker's Role

As might be expected from previous research, another area of tension between health centre workers and social workers centred on the question of the role of the social worker in the provision of services. Particular attention has been paid in previous studies to the problem of role conflict between health visitors and social workers and the factors which make the relationship between these two groups especially prone to misunderstanding and conflict. (DHSS, 1969; Fry, 1965; Hicks, 1976; Huntington, 1981; Dingwall, 1976). This issue was especially salient to the participants in Health Centre B who called for a meeting with representatives from the area team to discuss their expectations regarding their own and each other's role. Certain health service workers took exception to the role definitions provided by social workers and spontaneously commented on this issue during the interviews.

Dr Ivory: "The problem was role definitions, we haven't a common ground on this frankly. Our idea of their role is different from what they think, which isn't surprising really. They see their role in a more sophisticated way than we do. They also discussed areas that they thought were their remit; the bereavement thing came up then. They seemed to think that they had a role in counselling the bereaved and we didn't see them in this way".

The community psychiatric nurse was of the opinion that the claims made by social workers to specific forms of expertise and their ability to deal with particular types of problems were neither appropriate to the needs of the patients and health centre staff nor practical at the level of service delivery.

Mr Miller: "I don't see how anyone can say that it's their job to cover bereavement. Anyone can be there ... it might be a neighbour, the district nurse, the

chaplain, the relative of the patients, or the social worker. It really depends on who's been there throughout the ordeal. However, the person has to have a reason for being there in the first place, i.e. I might have been visiting the patient in order to give them their Lithinal injection in which case I might take on the role of bereavement counsellor, the district nurse may have been visiting the patient in order to change dressings so she might take on the role. That's what I object to, someone saying that they will do bereavement visits. We all have varying degrees of expertise and experience. It really depends on whether or not the family likes you and trust you. But, you don't get this trust by being a health visitor, or a GP or a social worker".

Attached health service workers, like the general practitioner, looked for some practical reason for the social worker becoming involved with or entering into the domestic life of the patient.

Such statements and sentiments as these may be interpreted by social workers as yet another example of the general medical practitioner's attempt to exert 'medical dominance' over another professional group by defining what is the right and proper area for the latter's concern; a function which social workers would, legitimately, see as better left to themselves. From the social worker's viewpoint, the doctor's attitude was viewed as an unwarranted intrusion into their own affairs. Aside from the dispute over whose responsibility it was to deal with a particular type of problem, in this case bereavement, the debate extended into broad areas of practice which every member of the team could legitimately be expected to treat, the treatment of 'emotional problems'.

Dr Nelson

"... if a patient presents to me with an emotional problem I would see it as an aspect of my role because the patient happened to be there at the time and I happened to be there. I wouldn't say

'Ah, an emotional problem, I'm going to refer you to the social worker'. Whoever is in that position at that moment, it could equally be the health visitor, the district nurse and so on, deals with the problem as best they can".

A number of studies have shown that doctors vary in terms of their personal and professional definitions of the range of activities and types of problem which they regard as their responsibility (Horobin and MacIntosh, 1977). Practitioners with a broad definition of their area of responsibility vis-a-vis the patient regarded the social worker's definitions of their role and remit as overlapping the work already carried out by the general practitioner and complementary para-medical staff, e.g. health visitors, district nurses, etc. The problem of conflicting role definitions is likely to be made problematic in the event that the doctors hoped for a professional colleague who would fill any gaps in the services already provided by medical personnel. Thus, there was conflict surrounding the social worker's expressed lack of interest in dealing with 'financial problems'. Social workers who claim expertise to practice in the same areas as medical staff were therefore greeted with some hostility.

Changes in the organisation and provision of the health and welfare services have presented doctors with new dilemmas. If the general practitioner genuinely wanted to develop a 'team' approach to patient care, he is faced with the quandary of simultaneously relinquishing part of his traditional authority and unique responsibility to the patient. Hopkins (1974) in an article supporting the notion of 'personal family doctoring' suggests that the doctor's sense of security is threatened by the diffusion of personal responsibility for patients. The claim made by social workers thus posed a threat to certain doctors, a situation

made worse in the absence of close working relations between the area team and the health centre staff.

Further, the social workers appeared to define their role in abstraction, without reference to the abilities, skills and expertise of others in the medical care system. That is, where the participants defined their own role, and that of others in the primary care team, as fluid and open to negotiation, social workers were seen to make claims to expertise and competence without reference to other groups. Some of the health centre workers may have felt that their own contribution to the care of the patient was under-valued, not taken into account, by social workers. In addition, they were of the opinion that social workers were engaged in a process of 'encroaching' into the 'medical domain'.

Nurse Jade: "I think they would like to be greatly involved in medical aspects of care, care of the dying, bereavement and care of children who are handicapped. They don't even do what they say they're supposed to do and they still want into these areas where the health visitor and the GP are involved. They're trying to extend their role where there is already medical involvement".

On the basis of these statements, it would appear that when social workers declared an interest in what medical personnel defined, implicitly or explicitly, as 'their territory' medical staff also assumed that as part of the bargain they could legitimately expect to monitor the activities of the social worker practising in these areas. The perceived failure on the part of the social worker to fulfil their expectations even in a single instance, reinforced the health worker's

belief that social workers had little part to play in the provision of services to select 'patient' groups.

The stated interest of social workers in counselling the recently bereaved and the handicapped, an area of interest which, on empirical grounds, cannot be said to be a purely medical problem, also posed a threat to a number of health centre workers. One health visitor made the candid observation:

Nurse Henry: "Ah that, I don't feel threatened with the idea of the attachment but I did feel threatened when they started talking about bereavement visits and dealing with the handicapped. We've only just started doing bereavement visits ourselves. I guess we've been expanding into their area of social problems and we worry about their expanding into our area; it's a very grey area".

Another comments:

Nurse Innes: "We're at fault as well, oh God when someone says that they want to be involved in bereavement you see it as a threat to yourself. Whenever it's brought up it gives us a sense of being threatened".

The underlying sense of professional insecurity experienced by members of the primary care team, manifest in role boundary disputes, may be accounted for in a number of different ways. Certainly the first and most obvious explanation rests on the fact that certain types of problem represent 'grey areas' where no single professional group could lay outright, legally sanctioned, claims to having a mandate to practise. In addition, as one of the respondents noted above, the fact that the health visitors had themselves only recently reached an informal agreement with other members of the medical team, notably the individual doctors to whom they were attached, may have contributed to

their professional insecurity. That is, their involvement in certain types of cases was not long established and had not become part of the routine pattern of patient disposal within the health centre.

This second point indicates another factor which must, I would suggest, be taken into any account of the relationship between health visitors, and attached staff in general, and social workers. That is, the sense of professional insecurity and the concomitant rise of inter-professional tension between 'competing' allied staff may be seen as a product, or consequence, of the type and nature of the relationship between doctors and their attached staff.

It is understood that much of the work carried out by health visitors is generated from their statutory responsibility to provide primary prevention among demographically defined sections of the population e.g. to pay a first home visit to the newly born following the final visit of the midwife. Dingwall (1982) argues that health visitors are the only significant group of nurses who are not directly dependent upon the medical profession for referrals. As a result, the structure of their relationship with physicians gives them more autonomy. However, it would appear from the statements made by the various health visitors in this study that the outcome of their negotiations with GPs may confer greater or lesser power and influence to one or the other of the negotiating parties. This observation will be taken up and expanded upon in a later chapter.

The areas of special interest outlined by social workers for special attention were the same areas that members of the medical team regarded as personally and professionally interesting and a source of

work satisfaction. The social workers will have been regarded as engaged in a 'boundary busting' exercise into areas of special interest to the medical worker. Such encroachment, again given the state of relations between the health and social services, would not have found favour with the participants, particularly if the social workers were simultaneously seen to avoid the more mundane problems and areas of work that participants assumed were part of the social work task.

6. Inter-personal Relationships

Unlike the general practitioners who rarely, if ever, ventured out of the health centre to visit the area team's offices, a number of attached health centre personnel reported that they had made infrequent visits to the local department. These forays into the social work camp were, in the view of some members of Health Centre B, an additional source of aggravation.

Nurse Jade: "I've been up there four times this year. I get put into a waiting room, then they can't find the social worker I'm looking for or I get told that the client hasn't been allocated. In the end I just don't want to know".

For other health workers it was not so much a question of where they were put as the style and manner of their reception at the social work office.

Nurse Park: "I used to go across, but not now. The last couple of times I went to see someone I was ushered by the receptionist into the waiting room. I really felt that it was a bit of a waste of time; it was cold and impersonal".

Nurse King: "Well, um, the relationship (with area team social workers) isn't satisfactory. I saw Mrs.

and I told her the problem with this family I was seeing. She wrote it down on her blotter, not even an official note or form. I was told that it wasn't their problem and that the family should get aid in (a nearby town) at the department's main office. She didn't suggest sending in a social worker and she took no details other than what she scribbled on her blotter. She said to me 'I expect you'll be back to me on this' and I told her, flatly, 'no'.

The health centre personnel held clear expectations about how they should be received by a fellow professional. When these expectations were not met, particularly in the climate of hostility and suspicion which characterised the relationship between medical and social work personnel, feelings of resentment toward social work and social workers were reinforced.

Relationships with the Health Centres: The Social Work Viewpoint

The representatives from the area team reported that the relationship between the department and the two health centres had become increasingly strained during the year. Unlike the health centre participants, however, the social workers saw this as a consequence of (i) the shortfall in the number of trained staff working in the area team, and (ii) the unabated demand for their services by clients and non-social work agencies serving the local area. In contrast to the health centre participants, the administrative grade social workers were less critical of the department's relationship with the health centres. The area team leader and the senior social worker reported that personal contacts with individual practitioners remained constructive and that certain aspects of the department's relations with the health centre were 'quite successful'.

Mr Carson: "We've had some success in achieving certain aims. The education bit still continues; doctors have been informed of what we provide. And, the exchange of information bit is successful although it varies depending on the personalities involved".

Despite their optimism, the social workers were critical of certain factors associated with their relations with the two centres. The problems highlighted by the social workers included:

- (i) issues surrounding the referral of clients;
- (ii) the 'personalities' of some of the medical practitioners; and
- (iii) the expectation of health centre staff that the joint health centre--social work meetings should be held within the centres.

1. Referrals from the Health Centres

The major point of contention between health centre workers and the area team was, according to the social workers, the type of referral made by primary care staff to the Department. The social workers described this problem as one of 'inappropriate' referrals. Both respondents found difficulty in expressing, in precise terms, what was meant by the term 'inappropriate referrals'. However, during the interview with the senior social worker, he attempted to explain the concept by means of illustration.

Mr Carson: "It would be easier for me to give examples. Doctors and health visitors refer anything that's not a medical problem to the social worker. That's the underlying cause of the problems we have. For example, families with no furniture. That's something the DHSS could deal with. Electricity supply disconnected, it would be just as easy for them to call the electricity board - they could do it. Arranging transportation for the patient to take him to hospital for some reason, because they

can't get an ambulance. Destitute people, that is a particular problem that I find difficult because doctors raise their expectations and we can't fulfil them. And the biggest single problem is that they ask us to take children into care for a variety of reasons. Once a child is in care the problem is solved for the GP but for the child and the family it's just beginning. These types of things are generally inappropriate. There may be underlying problems but at the point of referral they can't offer medication so they refer patients to us".

This description of 'inappropriate referrals' highlights a number of issues which are relevant to an understanding of the relationship between health centre and area team personnel.

Firstly, social workers felt that medical practitioners often attempted to 'dump' cases in the social worker's lap; and in so doing medical staff demonstrated that they did not take into consideration the range of professional skills, the expertise and the abilities of social workers to deal with more complex problems. As Ms Argent stated:

"They (health centre staff) approach the social worker with a problem and often there is nothing that we can do either. We're stuck with the situation. Quite often the health visitors will say 'could you see this family' where we know the child care standards are poor and the health visitors are not finding an adequate solution to the problem. So they call us and ask if we would take it on. What makes them so sure that we'll get in? Social Work Departments tend to be the end of the line. It tends to be a case of: if you're stuck - call the social worker. We're the end of the line really".

Secondly, referrals from the health centres, which, in the social worker's estimation, could have been dealt with adequately by either the referral agent or some other agency (such as the Citizens' Advice Bureau) were regarded as 'inappropriate' for social work intervention.

The social workers were especially critical of the referral of patients experiencing financial difficulties.

Ms Argent: "The impasse is that they also see us dealing with financial problems or the health visitor who asks us to procure a gas cooker. Because they don't want to do it, they see us doing it".

The respondents were aware, however, that the inter-professional tensions arising from inappropriate referrals was complicated by the fact that other social work departments defined financial problems as part of their remit and specific social workers in the area team had, at one time, provided such help in the past.

Mr Carson: "Of course there are offices that do pay electricity accounts regularly. These are usually in town where they don't have a lot of these cases. We'd have hundreds and hundreds, so we've had to decide not to take them up unless there's a child at risk".

He went on to say:

"We had a social worker here before Ms Bishop arrived who worked half time in Health Centre B. She was doing work on things that could, or would, have been taken up by the area team. Also she took things on that an experienced social worker wouldn't have done, just to keep them (the doctors) happy. For example dealing with financial problems and housing problems".

Finally, a referral was judged inappropriate when the referral agent presented the problem fait accompli with little, or no, reference to the ability of the social worker to carry out an independent assessment of the case.

Mr Carson: "We've had referrals and it's a case of the doctor telling us 'that's the problem, do something about it'. It takes a social worker who is confident in

his or her role to resist these kinds of demands and to make their own plans".

Faced with referrals such as these, in which the referral agent makes no reference to the assessment and diagnostic skills of the social worker, social workers may have felt that they were being treated as the 'hand-maidens' of the doctor and, that the referral agent was acting in a dominant fashion by defining the role of the social worker in individual cases. Attempts to prescribe action for the social worker were resisted, as the above comment suggests, by non-medical workers who see role definition as one of the prerogatives awarded to members of an independent profession.

Each referral from the health centre that was rejected by the area team on the grounds of inadequate resources may also have acted as a constant reminder to the area team workers of the restrictions and limitations within which they had to work. It is plausible that the continued demand for services by health centre workers and their apparent lack of appreciation and recognition of the problems inherent to social work practice might have increased the social worker's sense of frustration with both the medical staff and the circumstances in which she/he was forced to work.(4)

2. Inter-professional Relations and Problems of Personality

Both the senior social worker and the area team leader placed a good deal of emphasis on the relationship between the quality of inter-professional relations and the personalities of those engaged in inter-professional transactions:

Mr Carson: "The quality of contact always depends on the individuals involved; it has to do with the personality of the individuals. If you had a confident social worker and a realistic GP then the contact was very good".

Ms Argent: "I've contacted them once or twice about complaints. I had a letter of complaint from one doctor. I asked to see him personally to discuss the problem, but I had no response. It's a problem of personalities really. Some of them really are quite aggressive".

The manner in which medical staff presented themselves to the social workers was thought to have an impact on the relationship between the two services. Respondents also commented that health centre staff tended to be 'aggressive' when putting forward cases for allocation. Ms Argent went on to comment:

"The aggression really is difficult to cope with. There have been times when the health centre, as a group, have attempted to pressurise an individual social worker to take up a case. If we felt that it wasn't an appropriate case to be taken up by the department, the social worker could be faced with a lot of pressure".

The attached social worker observed:

Ms Bishop: "There is a lot of ill feeling toward the doctors because the Social Work Department isn't able to deal with the cases referred by the GPs. Doctors refer things that aren't dealt with adequately and they (the Local Authority Social Workers) feel that the doctors are always on their backs".

The second point, the strident efforts on the part of the health centre personnel to bring pressure to bear on the social worker owed less, I would suggest, to the 'personalities' of the medical staff involved and more to a decision on their part to employ a particular tactic, or style of presentation, vis-a-vis the social work department

in order to gain results. One doctor stated freely:

Dr Craig: "Unless I scream and threaten them with 'unless you take responsibility for this case something is going to happen - and you'll end up in court' - then things do happen. It happens but acrimoniously and even then it doesn't achieve much".

Other health centre workers admitted adopting much the same type of approach to the Department, which social workers, as did some of the attached health centre workers, found unproductive in terms of building relations between the two groups.

3. Venues

The final criticism made by the senior social worker concerned the fact that the joint social work/health centre meetings were consistently held, and medical staff expected them to be held, in the health centre.

Mr Carson: "The problem is that the meetings are always held in the health centre. It's always on their home ground. Which means more people from the health centre attend than from the Department".

The failure on the part of the medical staff, and especially the doctors, to make concessions and demonstrate their interest in social work by meeting in the Department's offices did little to encourage social workers to take a more positive view of medical staff. Resentment may therefore have been bred as a result of the social workers having to make an effort to meet in the centres - an arrangement which was only reciprocated in the event that special meetings, such as case conferences, were arranged.⁽⁵⁾

SUMMARY

The findings show that at one time attempts had been made to develop a structure within which a closer working relationship between medicine and social work could be promoted. However, any advances which had been made in bringing the two groups together had, according to the respondents, been reversed in the period leading up to the attachment.

• Results from the interviews and informal discussions with staff before the start of the attachment scheme show that they were without exception censorious of the local social work department. While a minority of the staff viewed their relationship with the occupational therapists and the social workers who had at one time acted as 'liaison' social workers to the centres in a positive light, they were universally critical of their general inter-personal and inter-professional relationship with the local authority social workers. A number of factors were causally linked with the deterioration in health centre—social work relations and these have been identified. The deterioration in relations was, according to the participants, causally linked to changes in the structure and process of allocating work to social workers, the change from a 'patch' to a team system. However, analysis of the data revealed that many of the problems highlighted by the health service workers were a result of more specific differences in terms of the methods of work and administrative arrangements characteristic of the two services. One of the major sources of dissatisfaction amongst the health service workers stemmed from the absence of a single, identifiable social worker whom they could contact, on a one-to-one basis, as problems arose.

The health centre workers resented the length of time social workers required to make allocation decisions about referrals from the health centres and the department's use of a 'priority list' to rationalise service delivery. With respect to the latter, the interviews revealed what may be best described as an underlying sense of professional jealousy amongst para-medical staff. Health centre workers envied the ability of social workers to treat referrals selectively and thereby avoid what the respondents thought were the more mundane areas of work, e.g. financial and housing problems.

The differences in practice ideology between the physicians and social workers manifested in their different views of priorities shows, perhaps above all else, how the general practitioner has been removed from the centre of the decision-making process related to patient care. With the establishment of an independent social work department the doctor was unable to instruct or command social workers to take up their referrals. Further, the structure and organisation of the area team made it difficult for the physician, or anyone else, to exert their influence in the social work--medicine relationship.

Health service staff were also highly critical of the amount and type of information they received from social workers. Feedback, or more precisely the lack of feedback of information from the department about patients held in common was considered a major stumbling block to the development of more positive inter-professional relations. The problem was considered more acute by health service workers than the general practitioners due to their commitment to working with patients in the home. Deficits in information were thought to lead to an unnecessary duplication of effort and a waste of their professional time

particularly in relation to home visits.

Unlike the general practitioners, who rarely if ever ventured into the precincts of the Social Work Department, those health service workers who had visited the Department made adverse comments about the reception they had received: they felt that they were treated in a off-hand fashion and in a manner which did not befit a fellow professional worker.

According to the representatives from the local social work department the relationship between the department and the health centres had become increasingly strained during the year leading up to the attachment. The break-down in inter-professional relations was attributed to the demand placed upon the department's resources by the health centres, among other sources of demand, at a time when it was operating at a level below establishment strength.

While the area team leader and the senior social worker expressed positive views about certain features of the department's relationship with individual practitioners, a view which was not necessarily representative of the area team as a whole, they felt that the majority of the practitioners were often guilty of making 'inappropriate' referrals. The social workers also expressed the view that health services often treated the Department as a 'dumping ground' for patients when all else failed.

The social workers felt that the personality characteristics of some of the health centre practitioners occasionally acted as a stumbling block to the formation of a more positive and co-operative

relationship between the two services. Certain doctors were seen to act in a particularly aggressive and hostile fashion toward the Department and individual social workers.

Finally the social workers' perception that health centre staff appeared to expect the joint social work--health centre meeting to be held in the health centres was a source of minor irritation within the department. As I will demonstrate in the next chapter, all of the participants viewed the attachment as a means of correcting the problems inherent to the medical--social work relationship and as a means of serving their interests.

CHAPTER THREE

THE SOCIAL WORK ATTACHMENT TO THE HEALTH CENTRE

The Region's executive social work officers wanted the attachment for a number of reasons. During the pre-attachment interviews the two respondents focussed on a number of articulated interests which they hoped the attachment would satisfy. These interests took the form of definite courses of action, or policies, which were designed to achieve certain goals. For example, they hoped that by establishing a social worker within the primary medical care setting the status and influence of front-line social workers would be enhanced in the eyes of the professional and lay public. In addition they anticipated that the spread of experimental attachment schemes to secondary settings would ultimately lead to a greater degree of contact between the executives of the social work department and the health board. My interest does not, however, focus upon the supra-ordinate goals of the executive officers. Rather I am more concerned with the attitudes and interests of the participants. More specifically I am interested in identifying the participants' initial preferred outcomes for the attachment scheme.

In this chapter of the study, I examine:

- (i) the participants' attitudes toward the attachment scheme;
- (ii) how they perceived the scheme; and
- (iii) what they hoped to gain personally and professionally from its implementation.

1. Participant Attitudes toward the Attachment

The participants were unanimous in their support of the attachment

of a social worker to their respective health centres. Their commitment in principle was such that many viewed the 'split post' arrangement, with the social worker dividing her time unequally between the two centres, as second best to what they had originally hoped to gain, i.e. a full-time, fully attached worker. The comments made by the participants in response to questions about the scheme suggested that their enthusiasm and support was based, in part, on their desire either to correct or avoid the problems they encountered with the area team. That is, they viewed the attachment of a social worker as the 'prescription', if not the 'cure', for the problems discussed in the previous chapter.

All of the physicians and nine of the attached medical and non-medical staff placed particular emphasis on the fact that they would be dealing with one identifiable 'named' social worker with whom they could develop a personal relationship, rather than a group of social workers.

Dr Elder: "We should have more cohesion with a single individual. It's a single person who we can relate most of the problems which, at the moment, are left up in the air as a result of poor liaison with the Social Work Department".

Dr Jones: "One of the most important advantages, as I see it, is that we'll have an identifiable person. It's someone that we know, with whom we can discuss problems, instead of dealing with a fairly large group".

Sister Flower: "The fact that there is only one person I'll deal with, that's a definite advantage. I find it problematic dealing with the whole group of social workers. Basically I'll find it more satisfying. It means I can have on-going contact with one person".

Mr Miller: "Also you could get around the problem of wondering who to relate to. It's having someone on hand to

answer our enquiries."

There is nothing new about these findings. Many reports of successful attachment schemes have noted the importance doctors place on the formation of informal, personal relationships as opposed to purely formal working relations in their contact with attached workers. (Goldberg & Neill, 1972; Forman and Fairbairn, 1968; Beales, 1976; Williams and Clare, 1979).

Despite the relatively widespread reporting of this feature of inter- and intra-professional relations, few studies elaborate why the personal element is considered important by medical practitioners and other allied professions. It may be of some value therefore to digress for a moment and examine in more detail why the participants, particularly the physicians, wished to develop personal contacts with their medical and non-medical colleagues.

Personal Contacts and Professional Relationships

Firstly, the doctors in particular felt that the development of personal ties with their colleagues was causally linked to the quality of service their patients received when in the care of another practitioner. That is, the treatment received by his patients from colleagues who were known to him and with whom he had a personal relationship was in some way qualitatively better than the treatment the patients would have received through formal channels, from relative strangers. The doctors theorised that the development of personal contacts bound the two professionals in a system of mutual rights and obligations which transcended those found in more formal relationships.

Dr Hall: "When there's more personal involvement with your colleagues, you feel that you have more personal responsibility to the patient who's referred to your practice".

Dr Ivory: "If you know them (the consultants) then you'll feel more obliged to help them with their patient (by accepting a referral) than if it's a formal letter of referral. If I have a tie-up in the hospital, if I have a personal contact with them I feel that my patients are dealt with better and quicker when it's a consultant that I know".

This system of mutual obligation was observed to form part of the medical sub-culture in both of the health centres. Practitioners were frequently seen to ask particular colleagues, with known clinical interests and expertise, to 'see what you can do with this patient' as well as asking for advice and information. Further, the system of obligations extended to attached medical staff, many of whom reported that they considered it part of their role within the primary care team to help 'carry' certain patients, with intractable problems, who were particularly demanding on the doctor's time.

It is also conceivable that by developing personal ties the doctor is placed in a position to exert inter-personal influence over his colleague; bringing personal pressure to bear by calling in debts, entering into reciprocal agreements and so on.

Another area which was thought to be affected by informal relations was that of exchanges in information. Again the nature of the relationship between practitioners was thought to have an impact on the quality of information received from other sources.

Dr Kelly: "You may have a better chance of getting more and detailed information from the person that you know. They're more likely to tell you the details about

the case; the details that aren't in the patient's records, that may have important implications on how you manage that patient".

In addition to the functional value to the doctor, the informal system of personal relations also permitted the practitioner to gain insights about the skills, interests, working methods and clinical competence of his colleagues. On the basis of such information the practitioners were able to make adjustments in their transactions and negotiations with their colleagues:

Dr Lamb: "When you know them personally, you know what reaction to certain problems (referrals) will be, you know what they like, you know their weak points and limitations".

Dr Gold: "You develop an understanding of the ways that they work and how they think and you can make allowances for certain characteristics, and they with you. Then you can be more honest and informal - and more critical: I think that there's a greater willingness to accept criticism from someone that you know. It's more difficult if you don't know the person or you're dealing with successive numbers of them".

Moreover, the development of personal relations with professional colleagues fostered a sense of 'trust' based on mutual understanding and sympathy. The doctors also reported that they found it easier referring certain patients to colleagues whom they know personally, particularly in situations where the referral agent was uncertain what the problem was and what he wanted from the referral. By developing personal contacts the referral agent may have felt less vulnerable to status loss when disclosing their uncertainties and limitations.

Dr Gold: "It's O.K. dealing with someone formally if what you're after is a precisely defined service in terms of what takes place and the time that it occurs. It's easy when it's a nice sharp, specific

problem. I don't really need a personal relationship with a surgeon if the patient's gall bladder has to come out. But if you want your suspicions confirmed about a particular component of the family, and if the problem is likely to recur and if it's a dynamic situation in relation to the patient then you do need a personal relationship. You want the possibility of a dynamic social relationship with the other people involved". (Speaker's emphasis).

Comments such as these are of particular importance when applied to the doctor's relationship with social workers. The social problems encountered by general practitioners are not easily defined and rarely amenable to a quick remedy. When faced with the decision of whether or not to impart their findings, or suspicions, about the social and emotional details of their patients' lives to a third party, they found the exchange easier if the intended recipient was known to them personally.

Dr Lamb: "A lot of issues are, by their very nature, sensitive and delicate and a personal relationship (with the other professional) is essential. Also mutual trust can only be developed along these lines ... things can be said (face to face) about a situation, especially when it's of a personal nature, which one would hesitate to put over the 'phone or in a letter. You have to be very careful about what you say over the 'phone as lines could get crossed".

The practitioners' desire to form contacts based on a personal relationship was in response to a range of structural, situational and inter-personal factors arising from the organisation of the medical profession. By developing informal relationships the doctors hoped to mitigate some of the problems encountered in their formal role relationships with medical and lay colleagues.

2. Attachment and Personal Relationships

It was not surprising that all of the doctors placed great emphasis on developing a personal relationship with the attached worker, a feature which was absent in the relations with the area team. The doctors drew causal links between the formation of this type of relationship with the attached worker and changes in their formal association with social work, particularly in regard to the referral process. As one doctor commented:

Dr Baker: "A personal relationship will make referral easier. I'll find it easier to refer patients who need social work involvement. And, hopefully, I'll be more satisfied with the personal contact. I'll feel that things are being seen to. I'll feel more relaxed if I can check from time to time on how the patient's situation is developing".

Their prediction that the attachment would bring such rewards was based on a number of assumptions.

Firstly, the spatial and geographic proximity of having the social worker based in the health centre was thought to have an effect on the ability of staff to contact and involve the social worker as the need arose.

Dr Nelson "I envisage both formal and informal contact (with the attached worker) with greater emphasis on informal contact. For this reason the social worker should be available to spend a significant amount of time in the health centre so that we meet up with him or her".

Secondly, the doctors assumed that by having an attached social worker the structural barriers existing between the two services would be weakened. By forming a personal relationship with the social worker

they would be able to negotiate new terms and conditions for referral which more accurately met the needs of the doctor and, it was argued, his patients.

Dr Craig: "Once again, from my point of view I'd like her to accept one major thing that I think is very important. When something is done it must be done over the shortest period of time. Also, she must work out where she stands in relation to a referral and tell me that she is doing this and not doing that; that she can do this, but can't do that".

Dr Hall: "I expect her to make rapid decisions in terms of what she will or will not do or wants to do in the way of referrals".

And thirdly, it was assumed that the practitioner would be in a favourable position to monitor the professional activities of the attached worker once a referral had been made (the evaluation of subordinates' performance).

While the majority of doctors commented that they hoped to establish a personal relationship with the social worker, the form, in specific terms, that these relations were to take was largely undefined. The social worker therefore ran the risk of stepping into dangerous territory; what may have been defined as a welcome personal relationship with one doctor may have been defined as an unnecessary intrusion by another. On the other hand, a hesitancy on the part of the social worker to form a personal relationship with the doctor could be interpreted by the individual practitioner as indifference and lack of interest.

In only one case the doctor predicted that his relationship to the attached worker could have important implications on his perspective of

the area team social workers.

Dr Gold: "We'd have the opportunity to get to know and like the person which would foster a greater understanding of social workers. I think that we have a stereotyped image of the social worker because we don't know what their problems are. I think we see them as bodies who are not interested in 'problems' but more interested in 'techniques'. I think on our part morale would, on the whole, improve".

The majority of the physicians placed greater emphasis on learning something of the skills and abilities of the attached worker than the technical skills and competences of social work in general. Even at this early stage there was a tendency amongst physicians to particularise information about a social worker rather than think about social work in general. Indeed, their primary interest was not to learn something about social work practice but to bring a part of social work, or a social worker, under their control.

Finally, the development of a trusting, personal relationship with the worker was associated in the minds of certain practitioners, with a sense of relief from the strain of dealing with certain problems which they felt either unable or ill-equipped to deal with themselves.

Dr McAdam: "(With a personal contact) I hope to gain a certain relief from the feeling of not being able to cope with certain problems and I'll have the knowledge that there is someone I can share the problems with".

The doctors certainly felt 'out on a limb' when they encountered certain types of social problem, e.g. financial problems, problems of suspected child neglect/abuse. This uncertainty was, in all likelihood, exacerbated when they encountered area team social workers who refused

to allocate, or become involved with, certain cases. The possibility of having an attached social worker on hand who would be prepared to offer the doctors an 'on demand' personal service was, therefore, of great value to the doctor seeking social support in the case of particular patients and patient groups.

3. Attachment and the Medical Viewpoint

As a result of their transactions with area team social workers a number of doctors formed the impression that social workers had a tendency to either undervalue or ignore their opinions about a given case.

Dr Dean: "I think we, meaning my partners and I, feel that the social workers by and large have less experience of the circumstances in this area. Many of them have just started working here recently and they don't pay attention to what we have to say. We feel that we can identify the helpless and the needy. I don't know why this should be; I think, in part, it has to do with the unsettled nature of the team".

This view was, perhaps, reinforced in cases where the social worker's interpretation of the client's problem ran counter to that of the doctor. The doctors expected that with the attachment of 'their own' social worker they would gain a professional colleague who would appreciate (i) the medical content of social problems, (ii) the way in which they organised their practice to deliver services to the patient, and (iii) the ideas, opinions and wishes of the doctor in the treatment and care of the client.

Dr Fair: "It's having one person who is familiar with the set-up (of health centre organisation) and knows our way of working and knows one's cases".

Dr Dean: "We want someone with an understanding of our role and the contribution we have to make to the patient. The social worker must be conversant with this".

Dr Hall: "We'll be able to discuss cases with someone from a different background, someone who appreciates the medical context of the (social) problems".

On one level it appeared that the doctors were looking for a non-medical colleague who would demonstrate her understanding and appreciation of the problems inherent to general practice and the organisation of primary medical care. On a more practical level, however, the doctors hoped that the social worker would embrace a 'medicalised' version of the patient/client and his problems. In so doing the priorities applied by the social worker, on a case by case basis, would reflect 'medical' as well as purely 'social work' concerns.

Dr Nelson: "I'd like to see the social worker be in a position to effect a reduction in priorities. At present there is a certain amount of work, that is legally required work, that takes precedence as it is required by law. I'm not convinced that this work is the most urgent or the most useful. I feel that the work referred by the general practitioner and the health visitor has to take second place to the courts and the panels and I'd like to feel that the work we refer was dealt with with the attention and priority we think it deserves".

Dr Fair: "To my mind there are terrific advantages in having access and direct communication with an attached social worker. I think in so doing it will be much easier to allocate high and low priorities to our urgency of referral". (Speaker's emphasis).

Since the reorganisation of social work into a unified, independent bureaucratic organisation a central problem which has confronted physicians, individually and collectively, is how to achieve maximum control over relevant aspects of the social worker's work and her

problematic. The attachment of the social worker to the health centre was thought, at least by some of the participants, to create the necessary conditions for the physician to exert 'medical dominance'. The attachment of the social worker was seen as an opportunity for the physician to influence, guide and control the social worker in such a way that she would organise her work and her problematic around the general practitioner. The participants anticipated traditional forms of medical authority would be initiated, stabilised and maintained through personal face-to-face contact with the social worker in the medical setting.

In addition, all of the doctors looked forward to the social worker structuring her work in a fashion similar to their own.

Dr Fair: "The advantage (of attachment), as I see it, is the geographic proximity, the fact that she has a caseload that equates with our own patient list".

That is the social worker would provide services to the community based on a 'patch' system which the doctors regarded as the best form of service organisation on ideological grounds.

Dr Nelson: "We do work geographically and they (area team) have another basis. We are believers in the 'parish' system".

This overlap was thought to facilitate the development of a common stock of knowledge about the patient and his problem amongst all members of the primary care team while allowing first hand discussion with the social worker about patients/clients held in common.

Indeed, some doctors felt so strongly about the social worker dealing with the patients on their list that they regarded any work

generated outside of the health centres as a possible threat to the integrity of the social worker and the operation of the attachment scheme.

Dr Craig: "If she wants to do a good job of it in here it's important that she's independent and doesn't get involved with work generated by the social work department at a different office across the road".

Dr Elder: "The social work department is a shambles. I had to talk with some of my colleagues and we decided that we'll have to protect her. We'll have to protect her from any work that the area team wants to put on her. If they start they'll just absorb her into their work".

This paternalistic concern for the social worker's caseload no doubt stemmed from the doctors' fear that their own interests and the interests of their patients would be compromised if the attached social worker was drawn into the work of the area team. Such a situation would undermine, in the doctors' view, the potential benefits arising from the attachment scheme.

Finally the doctors held the expectation that the social worker would offer the patient an 'on demand' service similar to their own.

Dr Lamb: "Another advantage is the facility that the patient can contact the social worker here ... People who are in immediate need can be dealt with in the same day in this building which is a great help to the patient".

Dr Nelson: "With attachment there's the possibility of having consistent work done with the client. The client isn't going to be passed on from one person to another. That's what we're all about and I'd like to see it in the social worker".

Staff also looked forward to the social worker making herself

available to the primary care workers and their patients as the need arose or an 'on demand' service. Typical comments were:

Nurse Brown: "The fact that she's here and we'll know that she's here and we can contact her. I think that's one big advantage to be quite honest".

Sister Edge: "The attached person is on tap for immediate problems. I'll know when she'll be in her office".

Nurse Jade: "I want her around, to be here, like us. We're always in here (the health centre) between nine and ten each morning and people know when to contact us. There is nothing more annoying than the last two (social workers) that were here who would say that they'd be in at two and who would appear at three".

Sister Flower: "I'll know when she's going to be around, where she's going to be so that I could be more organised. Then we could meet and develop a personal plan for the patient or say that no one is going to be involved. I'd know where and when to contact her".

Attachment and the Referral Process

As I have reported in an earlier chapter, the participants felt frustrated by the length of time it took, after a referral had been made, for the area team to arrive at a decision about the allocation of a case. The participants therefore regarded the attachment of a social worker as a means of short-circuiting this arrangement.

Dr Abel: "We'll be able to pass on cases at short notice, earlier rather than later. It's availability, when the problems arise we'll have someone on hand to deal with them immediately".

Dr Baker: "It's someone there when you need them in the sense that when a crisis arises, she is there to go into the situation".

Indeed they tended to see the attachment as a means of avoiding contact with the area team. Comments like Nurse Curry's were typical:

"I think we'd have a more direct service and better liaison between us and the social worker. She'll be on hand to discuss the problems, as they arise, instead of our having to go through channels and wait for the social worker to be allocated to the case. A more prompt and efficient service; we'll get prompt feedback and prompt follow-up and we can discuss the cases while they're still fresh in the mind instead of going through reception and finding that they're all at a meeting or that we're not able to speak to them".

Two doctors commented:

Dr Lamb: "Once the attachment is under way referrals can be made on the spot. We wouldn't have to refer patients to the social work department".

Dr Jones: "If I know that the social worker is along the corridor three mornings a week, we can talk to the social worker that one knows rather than writing to the social work department".

In addition they also regarded the attachment as a means of providing 'preventative' social work. That is, the attachment was thought to facilitate the social worker's early intervention into a problem before the situation reached 'crisis' point.

Dr Craig: "It's somebody to discuss cases with who is prepared to say what she can and cannot do. That way she can look at problems well in advance of them becoming a crisis. Say adoption, which is a proper social work function, the problem can be sorted out before it happens not after the events take place".

Attachment and Communication

It will be recalled that the participants were critical of the

perceived failure of area team social workers to feed back information once a referral had been made. Further, when information was forthcoming from the social workers they tended to provide an edited or truncated version of what they knew about the case. Again, the health service workers regarded the attachment scheme as a possible solution to this problem.

Dr Baker: "In terms of feedback, we'll have closer follow-up and discussion about cases. We'll have more frequent contact in fact with an attached social worker".

A GP/psychiatrist noted:

"With an attached social worker we should have more information on problem families than we have now. Particularly in the case of families who present regularly with minor complaints which I suspect are psycho-dynamically based".

They hypothesised that once they had a social worker based in the health centre her close physical proximity would result in improvements to the frequency, direction and duration of contact between the various members of staff and the attached worker. Concomitantly, improvements in contact were linked to changes in the quality of information that was exchanged between the members of different disciplines; the content of the information would become more detailed than that passed between doctors and area team social workers.

Nurse Curry: "We'd work better as a team. We could discuss the case as it arose as soon as you come in from seeing how things are set up. It's fresh in your mind and we could move more quickly. I want better liaison and a more prompt reply and more continuity of care".

Sister Dollar: "I'd like to see more feedback, more discussion to tell us what help they've offered the patients and to tell us what they're doing. You'd both know the patient and know what each other was doing; sometimes the left hand doesn't know what the right hand is doing. If I had feedback I'd know that the message was received and acted on".

The participants also held very clear cut expectations about the form that these transactions with the attached worker were to take. As I mentioned earlier, the practitioners viewed purely 'formal' contacts with colleagues in general and social workers in particular as unsatisfactory. This may have been due to the fact that the participants reported that they often experienced difficulty in organising their thoughts, conceptualising the problems and expressing their concern about social problems. The attachment was seen as the means whereby informal, open-ended discussions could spontaneously take place between medical staff and the social worker.

Dr Jones: "We can discuss cases in a much more informal, 'chit-chat' sort of way. When she's here we can ask 'how are so and so getting on'".

Dr Lamb: "Her presence here will be an advantage just to discuss how to help a family in a given situation. And we can make referrals over coffee or give her a ring".

It is of note that when questioned about her relationship with the area team, Dr Lamb expressed concern about disclosing information to area team social workers over the telephone. Yet, in regard to the attachment, informal referrals made 'over the phone' were viewed as a viable proposition. This may be explained by the fact that the doctor anticipated having greater access to the social worker once a referral had been made, and the possibility that she could follow up cases at

regular intervals with the attached worker. Indeed, these informal contacts and the opportunity to get to know the attached worker were regarded as the 'cement' which bound the various members of the health centre into a 'team'.

Dr Kelly: "I hope that there will develop a team approach (to patient care) with active feedback and negotiation of roles in a particular case".

Dr McAdam: "We'd have someone on hand to discuss cases with and get feedback. If people are here we can exchange information with them, use their services and see them as part of the team".

The perceptions of and expectations about the attachment scheme outlined above were influenced by the participants' perception of their relations with the area team. They hoped that as a result of the attachment of a single identifiable social worker, who was physically present in the building and dealing with the same pool of patients as themselves, the deficiencies in their relationship with the area team outlined in the previous chapter, would be resolved.

There were, however, other determinants which influenced the participants' perception of the scheme. These factors represent a high order of beliefs and values and may be defined as their ideological viewpoint. This ideology was based on a concept of primary care as a multi-disciplinary endeavour.

The Ideology of Attachment

The participants' belief that the attachment of a social worker was a necessary and desirable adjunct to the already extensive services delivered from the health centre, was based on an ideological commitment

to the development of a multi-disciplinary approach to patient care. This ideology was composed of a series of discrete but inter-connected opinions and ideas about the nature of primary care and the future organisation of general practice which formed a coherent system of beliefs. The component parts of this ideology appear to be based on the belief that:

- (i) the problems encountered by practitioners in primary care were multifactoral and included the physical, social, psychiatric and emotional state of the patient;
- (ii) many of the problems were beyond the scope of the health service worker's training and experience, and further that the structure of general medical practice did not allow the practitioner to investigate, identify and treat certain types of problems adequately;
- (iii) having identified certain types of social and psychological problems it was the responsibility of the practitioner, particularly the GP and the health visitor, to refer such cases to the appropriate agency;
- (iv) therefore, primary care of necessity required a multi-disciplinary approach for the treatment of certain problems.

Thus,

- (v) the attachment of a wide range of staff, including the attachment of a social worker, would extend the services they could provide;

- (vi) such extensions would, by their very nature, have an impact on the quality of care received by the patient;
- (vii) such developments could best take place in the health centre setting.

As a number of the participants commented:

Dr Deans: "I'd like to see the health centre as something more than it is now. I'd like to see it as a base for a wide range of services, and not just medical services, for the people in the community. I'd like to see it extend to include medical, social, educational and voluntary services".

The commitment to this extended model of primary care was embraced to greater and lesser extents, by the majority of the participants practising in the two health centres. They viewed the attachment of a social worker as an end in itself, as an extension of the clinical services made available to the patient:

Dr Ivory: "We'll be expanding our team. It's yet another source of help, or advice, available to the whole team and the patients".

Dr Jones: "The attachment will be useful as a positive something else to do with the patients. This will be an additional resource and source of care for the patient. It represents a greater totalling of help that will be available to the individual who's in trouble".

For the majority of allied health service workers, the simple fact that the attachment of a social worker represented the addition of a new specialty to the extensive services already provided from the health centre was enough justification in itself for their support of the proposed scheme. These workers expressed the opinion that without the

attachment a gap in health centre services would exist to the detriment of staff and patients.

Sister Dollar: "Any team with an added specialty will benefit from it. This might break down the barriers (between health centre and social workers). I feel that there is something to be done that isn't being done".

Sister Flower: "Primary care must provide all aspects of care. We've got most specialties in the health centre so I see it as logical that a social worker is here to provide her knowledge regarding any appropriate referrals that come up".

Staff were seemingly influenced by the fact that both health centres had acted, and continued to act, as a test bed for new approaches to the organisation and delivery of primary care services. On the basis of their own experience of working within these innovative centres, staff viewed the attachment of a social worker as the best possible means of delivering social work to the patient population.

Sister Dollar: "I've found that in our (nurses') room that I might overhear a conversation about someone that I know something about. Something that may be of benefit to the patient and of use to the health visitor. I can't do that with the social workers if they're up at (New Town) Street".

Mr Miller: "The beauty of this set up is being able to have Mrs Cartwright (the district midwife) come in here and say "Look, do you know what's happened with this patient?" We're not getting that with the Social Work Department. That's why it's important to have her here".

The relative success of previous attachment experiments appeared to encourage staff to accept new proposals which would have the effect of expanding the already considerable resources made available to the patient population through the health centre.

Nurse King: "I think that we'd, ah, get a full team. I think that social workers are the missing link. Everyone else seems to be involved. So the team will be complete ...".

Sister Dollar: "We were the first to try having a clinical psychologist and a community psychiatric nurse and it has worked well in both cases. Why not a social worker? It's better patient care, the patients will have an all round service".

Aside from their ideological commitment to the principle of attachment, the participants had some justification for suggesting that the type and quality of care that a patient received would be affected by the introduction of a social worker into the primary care setting. Some stated that rather than 'opening a can of worms' by delving too deeply into the patient's social and emotional state their strategy was, in the face of restrictions in social service resources, to turn a blind eye to certain aspects of a given case.

Dr Kelly: "At the moment, because of the state of the area team, we may deal with social problems by ignoring them unless there are obvious psychiatric problems associated with the patient's presenting problem".

Dr McAdam: "We'd offer a more comprehensive service to the patient and because it's an offer (social work support) it will relieve the GP of certain problems that we either aren't dealing with or dealing with inadequately".

In common with a number of studies of psychiatric institutions (Strauss et al, 1964; Goldie, 1977) the findings show that the practice ideologies of the participants reflect the interests of the various groups who were concerned to maintain control over both their practice with individual patients and a variety of aspects to do with the work

setting. The attachment of a social worker was therefore justified on the grounds that it was a necessary pre-condition for the performance of their work.

Personal Interest and the Attachment of a Social worker

If studies of bureaucratic organisations are anything to go by, social actors will pay considerable attention to personal career and status objectives when they consider innovation within their work setting (Dalton, 1959; Crozier, 1964; Burns and Stalker, 1966). Certainly status, prestige and remuneration objectives feature prominently in the minds of many doctors. (1)

A number of reports have noted that the doctor's relationship with the patient in the consultation setting is fraught with ambiguity and uncertainty. Indeed it has been suggested that part of the education of the medical student is geared to teaching the student doctors various coping strategies for dealing with problems of uncertainty. (Fox, 1975). Informal discussions with the participants revealed that they experienced a great deal of stress when confronted with particular problems. Thus, one doctor expressed the hope that with attachment:

Dr McAdam: "The social worker will provide me with the professional expertise which would render me free from these worries that I have for the patient".

Two nurses stated:

Nurse Art: "Satisfaction, I'll get more satisfaction from the knowledge that the clients are being looked after".

Nurse Brown: "I'll have more confidence, more confidence of what social workers do and, hopefully, I'll have the confidence that something is being done and I'll

know what's being done".

Some participants also expressed the hope that they would be relieved not only of stress but of certain types of work.

Dr Deans: "In our general practice she might remove some of the social work burden from ourselves. I'd welcome any agency doing that so long as I was kept in the picture. So in theory she might release some time so that we can deal with the clinical problems, so that we can concentrate on the 'real' problems of doctoring" (Speaker's emphasis).

Dr Fair: "I'd see the attachment as taking a burden away from some of the routine surgery appointments and home visiting".

For the para-medical staff who were called on by doctors and patients to perform social work functions, the introduction of a social worker was seen as an essential element for their own sense of professional satisfaction and well-being. By filling the gaps in service, subordinate staff hoped to be relieved of some of the pressures and tensions arising from conflicts with the doctor over their role and remit which, in many instances, included acting as the centre's lay social worker.

Nurse Henry: "Well, ah, I'll feel more in touch with the more drastic problems that are going on around us. We're (health visitors) all going in to see families where there are severe problems and we don't have the information to help them. We're going in frequently but the patients still aren't getting the support they need. I hope that I'll feel a lot happier because I won't be stuck with people I feel that I'm not helping and that I know need help".

Nurse Jade: "I feel that I could offer my clients, or patients, someone else who knows the facts better than me so that I wouldn't feel that I was leaving them in mid air".

For the attached community psychologist the introduction of the social worker was welcomed in the grounds that it offered her the chance of forming a coalition with another non-medical colleague.

Ms Grant: "It's another non-medical person in the building: it's having someone who is non-medical to talk to really, and who will present a non-medical viewpoint to the doctors".

The health service workers also valued the opportunity that the attachment would create for 'getting to know' the social worker as a person and professional. Knowledge of the individual worker was considered important on the grounds that it helped smooth the transfer of the patient from the care of one professional to another. Intimate knowledge of the attached worker was also seen as a way to reduce the alienating effects of dealing with what was seen as a 'faceless' bureaucratic department. The health service workers therefore looked forward to an increase in their sense of professional satisfaction once the social worker was in post.

Nurse Henry: "Also, the people I'm dealing with, I'd be able to prepare them for allocation to the social worker and I'd be able to prepare them in case they weren't allocated. Personally I'd feel a bit happier sending the family to someone that I knew I could rely on: I don't know the members of the area team".

Nurse Brown: "I'll be able to tell the clients that the social worker is Mrs So and So that they'll be seeing. I won't have to say 'I think you should contact someone in the local department'".

Nurse Jade: "I hope to be able to offer the patients something more concrete than just telling them 'I'll see what I can do' or 'why don't you try the social work department'. I'll be able to say 'I think you should contact Mrs (the social worker) at the

health centre' or 'I'll have a word with Mrs (social worker) at the health centre'." For others, notably the GPs, the ability to provide this range of services to the patient gave them a sense of 'vicarious' professional satisfaction.

Dr Jones: "The doctor sees his patient benefit from the services provided by the team and the patient's involvement with the team".

Dr Abel: "Patient care will be improved and family care in the community".

Two of the practitioners expressed the view that they were in support of the attachment programme on the grounds that it furthered their ambition to develop innovative approaches in primary care. In a sense, they valued the programme in terms of the rewards to their professional status and prestige vis-a-vis their medical colleagues and peers.

The participants hoped to gain rewards in terms of their security of practice and their status. With the attachment of the social worker they could lay claim to dealing with the socio-psychological and socio-emotional problems of their patients.

4. The Social Work Viewpoint

The area team leader and the senior social worker supported the concept of attachment. Indeed Mr Carson had been instrumental in attracting the attention of the department's planners to the possibility of establishing an attachment programme in the area. According to a number of sources within the area team, however, not all of the senior staff and basic grade workers shared this positive attitude toward social work attachment schemes to secondary settings, including the

health centres.

Like the health centre staff, the two representatives from the area team expressed the hope that the attachment would bring to a halt the deterioration in the relationship between the local department and the health centres.

Ms Argent: "Well, for me I've been longing to get her or him here. - With the deterioration in the relations with the health centres the attachment might put a stop to that".

Change in the relationship with the centres was based on the assumption that the attached social worker would facilitate, and improve communication links between the health centres and the social work department.

Mr Carson: "It (the attachment) will keep us in touch. It will improve communication between the health centre and the Social Work Department".

The three respondents were convinced that social workers had an important and legitimate role to play in the provision of primary medical care services. This belief was based on the assumption that many of the problems encountered in general practice were best described as 'social' problems rather than 'medical' conditions and as such better dealt with by a qualified social worker.

Mr Argent: "Well, it seems to me that there are purely physical complaints then there are conditions or stresses where the problem is unknown; but people go to the doctor with what is a social problem because they want someone to talk to. My own feeling is that the role of the doctor can fulfil this need to a lesser extent, perhaps because doctors have less time or they don't want to be bothered with the problem. So, they hand out pills. So, that sort of thing can be passed on to

the social worker".

Mr Carson: "I saw having a social worker in the health centre as appropriate because a lot of pseudo-medical problems tend to be social problems and at that point in time the social worker could pick up these referrals. The kinds of referrals doctors normally overcome by getting the valium because of a lack of understanding about what a social worker does and their knowledge that we, at the Department were under pressure".

Ms Bishop: "In general I think a lot of people present to the general practitioners without there being strictly medical problems. Traditionally people come to the GP with their problems. I see it as being more appropriate for the attached social worker to cover that kind of work".

Many studies which have investigated the patterns of presenting problems in general practice confirm the social workers' belief that on many occasions patients present to their doctor problems of a social and psychological nature. (Cooper, 1972a; 1972b; Shepard, 1972; Goldberg & Blackwell, 1970; Hannay, 1979).

The social workers also viewed the knowledge and skills which general practitioners and nurses employ in a wide range of practice situations as inappropriate to all but a narrow range of physical problems. In addition, the social workers were critical of the presumed authoritarianism of health service practitioners and the narrow physical outlook of medicine. It was therefore concluded that the introduction of a social worker into the health centre setting would in some way counteract the 'medicalisation' of social problems and the indifference of medical workers to the social and psychological needs of the patient. It can be argued that on the basis of such beliefs the social workers were making a claim for most of the medical work other than a limited

range of technical procedures and basic physical care.

In some ways the views expressed by the social workers were inconsistent with their earlier statements: the respondents had earlier criticised the doctors for referring cases which did not appear to have a medical component, i.e. referring patients with practical problems.

Like the health centre participants, the social workers held a general ideological belief which placed emphasis on the multi-factorial nature of the problems presented by patients in the general practice setting. In addition, they too believed that there was a need for collaboration and co-operation between the health and personal social services. However, they differed in their ideological views which were oriented to the work of the attached social worker and the division of labour.

The two administrative grade social workers differed from the majority of health centre respondents, by expressing some cautious remarks about the proposed scheme. While the area team leader hoped that the attachment would 'take the pressure off of the area team' her colleague commented:

Mr Carson	"In terms of work, it means we'll get more referrals that we might not be able to cope with. You encourage more referrals. In theory this isn't the case but in practice it raises expectations that can't be fulfilled".
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Secondly, social workers expressed concern that the 'specialised' post within the health centre would give rise to feelings of intra-professional envy amongst the attached worker's area team colleagues.

Mr Argent: "The other thing is that the jealousy bit could happen. That happens with any specialised worker, given that's what she is".

Mr Carson: "There's a definite risk of the (attached) social worker picking up the interesting cases and referring the rest to the area team. There may be a real risk if the attached worker is allowed to pick her own cases. Or, it may be inferred by people working in the area team. It's always been my concern and that's why it's important that the social worker is based in the team and works from the team although she works in the health centre. That way she'd be given support and people would keep in touch with what she's trying to do".

Finally, like the GPs who feared the attached worker becoming too involved with the area team, the area team leader and the senior social worker were concerned that the attached worker would begin to identify herself more closely with the primary care team than the social work team.

Mr Carson: "It's important that the social worker is based in the (area) team and works from the team although she works in the health centre. That way she'd be given support. Support in case she's used by the doctors in an inappropriate way or is overburdened with work".

Both the GPs and the administrative grade social workers expressed paternalistic concern for the welfare of the attached social worker and expressed the wish to 'protect' her from the unreasonable demands of the area team or the medical practitioners respectively. Such attitudes have been seen as characteristic of superior-subordinate relationships (Ben Sara, 1976). Further, their views of the attached social worker lead the more powerful parties to the attachment, the physician and the area team administrators, to treat the attached social worker as an object over which they were in open competition. They each expected the

social worker to participate in the social and practice life of their respective organisations and were prepared to compete for her attention in order to guarantee her participation.

In an attempt to avoid the emergence of some of these problems, the area team leader had negotiated with the executive officers from the regional department, a one month settling-in period. For the first month of the attachment it was anticipated that the attached worker would spend all her time working in the area team, getting to know her colleagues, getting to know the community and the resources that were available in the community.⁽²⁾

In addition they anticipated that the attached worker would become functionally integrated within, and an active member of, the local department by spending part of her time within the department, attending team meetings, describing the nature of her post to her colleagues and sharing with them her anxieties and concerns about her role. At an implicit level the area team leader and the senior hoped that the attached worker would take the time to establish what Resnick and Potter (1980) have called the 'worker's credentials' within the team. That is they hoped that with their help she would: convince her colleagues of the legitimacy of her post and the role she had to play within the centres and thereby generate a sense of mutual ethical obligation; establish her professional credibility in the team by demonstrating to her colleagues her competence by 'Being experienced within the organisation as a committed worker' (Roberts 1982); and by gaining the support of her fellow social workers.

Ms Argent: "She's going to be carrying a heavy workload and the team will need to support her, she'll have to

get this support".

The ideas that the social worker had about how the post should be organised and operated also differed markedly from those of the health centre participants in other significant ways. Health centre staff hoped that the attached worker would offer their patients an 'on-demand' service; that she would establish routine 'surgery' sessions in the centres; and that the patient would have the opportunity of making direct contact with the social worker without having to go through a member of the primary care team. These expectations ran counter to the interests of the social worker who stated:

Ms Bishop:

"In this post I could see that I could get bogged down by the caseload. I can't be quite so ruthless in saying, 'No, I can't deal with that'. It's unlike the allocation system in the Department where it's possible because someone else might be prepared to pick it up. It's up to me to decide whether or not I can or can't deal with a case".

In the hope of controlling her workload the attached worker went on to suggest:

"I don't plan to have a clinic time in the health centre, that's not how I work things. I'd like to take referrals because it's easy for a person to come here and consult one of the doctors initially. I'd prefer that and afterwards I'd visit at home ... I'm not sure about people referring themselves. I think this might occur due to the state of the local department. I'd really rather that this didn't happen, I'd prefer that they consulted their GP or health visitor first and then I'd depend on the primary care team to contact me".

Rather than operating a routine structured timetable in the health centre, the social worker hoped to maintain an open-ended system of client appointments. Further, in an effort to control her workload, Ms

Bishop anticipated using the medical personnel as a conduit through which clients had to pass, in order to receive her attention. Thus, the social worker hoped that the medical personnel would filter out clients who may otherwise have made direct contact with her in the centre.

Summary

The health centre participants were unanimous in their support for the social worker's attachment to the health centres. Their support for the scheme was based on a desire to find an acceptable solution to the problems and gaps in service they experienced in their relations with the area team. They regarded the attachment as a potential panacea for the various ills they associated with the area team. Firstly, they looked forward to working with a single identifiable social worker rather than an area team. This was felt to add to their sense of professional self-esteem in the sense that they would appear knowledgeable to the patient with regard to whom the patient was to contact.

The social worker based in the centre meant that she would be near at hand and contact could be made quickly and easily as the need arose. The health service workers also foresaw improvements in the content, flow and frequency of communication between the social worker and her health centre colleagues once she was in post. This too added, in the eyes of the respondents, to their sense of professionalism and their image of good teamwork.

The attachment scheme was explicitly viewed by the various occupational groups as means of pursuing other individual and collective interests. That is the group members had particular wants and short-

term, tangible, material collective interests which, with the attachment, could be transformed into actions designed to satisfy them (Mills, 1956). The physicians saw the attachment as a means of gaining control over their work and as a means of returning to the centre of the decision-making process in patient care, at least within the limited scope of the health centre. They assumed that once the social worker was in post they would have the authoritative right to direct her work and monitor her performance; that they would have the opportunity to influence her attitudes and behaviour; and that the social worker would organise her practice in a fashion similar to that of the general practitioner, and build her practice around the physician.

The para-medical workers saw the attachment as a means of escaping their prescribed role as the health centre's informal 'social worker', that they would have a new avenue along which to direct patients in need of the social worker's ministrations and as a means of reducing their dependence on the local authority social work department.

The senior social worker and the area team leader approved of the principle of social work attachments in general, and the attachment of a social worker to the health centres in particular. Their views were not, however, representative of the area team as a whole, many of the social workers expressed opposition to the scheme. This will be dealt with in greater detail in a later chapter.

The social workers regarded the attachment as a means of extending social work into the medical domain. They hoped that the attachment process would in some unspecified way 'demedicalise'⁽³⁾ a large part of medical practice by transplanting social work techniques and competences

into a new context and replace the physician's medications and nostrums with social work practice. The social workers' goals ran counter to the interests of the doctors who hoped that the social worker would adopt a 'medicalised' viewpoint of her practice by responding to or complying with the doctors' needs or commands.

The health centre participants and the social work department's social workers also conflicted in their ideas about the operation and organisation of the scheme. Both groups regarded the attached worker's involvement and integration within their respective groups at both a personal and professional level, as fundamentally important to the success of the programme. Thus the senior social worker and the area team leader wanted to draw limits around the attached worker's involvement with the centres while the health centre participants wished to 'protect' the worker from any demands placed upon her by the department.

Both groups of practitioners tended to regard each other as competitors for the time and commitment of the attached worker. The health centre participants hoped that the social worker would operate an 'on-demand' service so that patients could make direct contact with her without reference to a member of the medical team. In addition they hoped that the social worker would operate a system of routine 'surgeries' within the centres. The social worker on the other hand did not wish to establish surgery sessions in either health centre. She also planned to control her workload by using medical practitioners as a conduit through which the patient had to pass in order to receive her attention. The health service workers' and social workers' attitudes toward and perceptions of the attachment scheme acted as a potential

source of conflict in the attachment programme.

In this chapter I have identified certain key decision issues which had to be resolved to enable the different actors to attain their objectives and satisfy their interests. The conflict over decision issues centred on differences in the participants' initial preferred outcomes for the attachment scheme and the organisation and structure of the social worker's work within the centres. These decisions all had implications for the social worker's behaviour and are therefore of sociological interest for we have the possibility of the doctor (A) controlling or determining the social worker's (B) behaviour. It is also conceivable that the social worker could determine the outcome of the issues independently of the doctor. Alternatively there may be an element of negotiation and bargaining between the two over the conflict decisions. These various possibilities presuppose a whole range of methods, from simple verbal exchanges or commands to a range of complex manoeuvres involving tactics and strategies to achieve the outcomes favoured by the individual actor. The outcomes intended by the doctors to satisfy their interests and achieve their preferred outcomes indirectly meant that they wanted to produce compliant behaviour in the social worker. In situations where either one or the other of the actors fails to achieve the compliance of the other party to the interaction we could speak of control loss or control failure.

CHAPTER FOUR

SOCIAL WORK PRACTICE AND THE ROLE OF THE ATTACHED SOCIAL WORKER

The role and function of the social worker in primary and secondary medical care has been extensively researched and widely discussed (Goldberg and Neill, 1972; Forman and Fairbairn, 1968; Bruce, 1978; Bursill, 1978; Jenkins, 1978; Collins, 1965; Corney and Briscoe, 1977; Huntington, 1981). Many of these studies have shown a general lack of consensus between medical workers and social workers about the role of the social worker in the setting of general practice or the hospital. These differences in perception largely centre on two overlapping issues. Firstly, differences in expectation about the types of problem that the social worker could, or should, be dealing with, and secondly, the range of professional skills which are attributed to members of the social work profession. McCulloch and Brown (1979), for example, in a discussion of social work in general practice, found that doctors tended to regard the social worker as someone who dealt with problems of an essentially practical nature, (e.g. financial and housing problems) and whose armoury of professional skills were, in the main, limited to instrumental tasks, e.g. arranging placements, organising home helps and providing financial assistance. In contrast to this perspective, the social workers tended to stress the emotional and behavioural problems of the client as their principal area of work. The social workers also emphasised their professional skills which included a strong psychotherapeutic component. Similar findings have been reported elsewhere in the literature (Brandon, 1970; Olsen and Olsen, 1967; Butrym, 1969; Butrym and Horder, 1983).

The problem of intra-role conflict, defined here as situations in which the social actor is faced with incompatible expectations for his/her behaviour (Gross et al 1958, p.248), has therefore been identified as a major, contributing, source of inter-professional tension and conflict in the primary care team. Bruce (1978), reporting on an earlier study of the attachment of nurses to general practice noted:

3.20 ... Gilmore, Bruce and Hunt (1974) reported that the primary causes of inter-professional misunderstanding found in health teams they surveyed were associated with discrepancies between the perceptions which different members held of each other's roles and functions; this affected the value they placed on each other's contribution to the team and the extent to which they referred work to one another .

It is part of the conventional wisdom of programme planners, practitioners and researchers alike that problems of role conflict between health and personal social service workers stem, at least in part, from the medical workers' lack of knowledge about and understanding of social work practice. Hopes were therefore pinned on the attached worker 'educating' the medical team about the nature and content of social work practice, the services that social workers are able to provide the patient and the medical team, and the types of problems/clients that could potentially benefit from a social worker's intervention. Conflict over the definition of the social work role in general, and the role of the attached social worker in the health centre in particular, and the desire of the social workers to educate health service workers about social work practice takes on special significance for the present study. Firstly, conflicts over role definitions are

taken to represent conflicts over a range of decision issues to do with the division of labour in the medical setting, who will do what for the patient. By treating role conflict as a decision issue, insight may be gained into the way in which the actors set about to resolve such conflicts which would include, one might expect, the use of power and influence. Secondly, the perceptions that the participants had of the attached social worker's role and the role of social workers in general, before she took up her appointment, reveal the initial preferred outcomes of the participants for the social work role. As such these data will provide the necessary baseline information to examine the extent to which the various actors were able to achieve the outcomes, or interests, they desired.

I. Health Service Worker's Knowledge of Social Work Practice

To discuss social work, in descriptive terms, is to enter a conceptual and epistemological minefield. Such professional and training bodies as the British Association of Social Workers (BASW) and the Central Council for the Education and Training of Social Workers (CCETSW) implicitly assume that there exists a 'common core' of key social work concepts, methods, skills and forms of practice which quintessentially define social work. These 'core' elements are thought to have the capacity of being transferred to students in training. A brief examination of the literature reveals, however, that a consensus view amongst social workers about what constitutes the 'essential elements' of social work and social work practice has yet to be achieved. Indeed, the ambiguity, uncertainty, and diffuseness of social work has led one analyst to suggest that CCETSW, and by implication the training programme it sanctions:

... seem more concerned with going through the motions of acting on the basis of some presumed consensus than on developing the intellectual and professional resources of social work with a view to advancing the frontiers of training. It has singularly failed to establish a core of social work training which may lead to a minimum shared competence amongst those who are trained. (Hoghugh, 1980a, pp 21-22).

The problem of conceptualising social work practice is further complicated by the fact that writers tend to:

- (i) include different elements in a list of what they consider the essential or 'core elements' of social work practice to be;
- (ii) differentially rank certain characteristics in order of importance; and
- (iii) employ a variety of different terms to describe similar characteristics.

In order to describe the nature of the work carried out by social workers with individual clients a number of approaches and perspectives may equally be adopted. For example, the analysis may take the form of examining the purpose, or goals, of the work carried out by members of the profession with the client (changing relationships, affecting the physical/material environment of the client, attempting to support an existing social system etc.) One might also examine the theoretical constructs which underpin the social worker's involvement with the client in concrete situations (the use of social systems theory, ego-centred psychology, role theory etc.) One might also address the problem by describing the transactions which take place between the social worker and the client (counselling, advising, providing

information etc.) (DHSS, 1978).

For the purposes of this discussion, the decision was taken to examine the participants' knowledge of social work practice in terms of the third approach outlined above; focusing upon social work practice from a transactional point of view. A number of considerations were taken into account when making this decision:

- (i) preliminary, informal, discussions with the participants revealed that this approach most accurately approximated the way in which they described the work done by social workers with their clients;
- (ii) although social workers might define the nature of their work in other ways (e.g. a recent Department of Health and Social Security Report (DHSS 1978) found that social workers classified their work in terms of focus, e.g. individual, group and community work, and duration, e.g. long-term, short-term contact with the client) a description of their work based on their transactions with the client is more understandable and accessible to both medical and social work personnel; and
- (iii) finally, previous research tends to cast some doubt on the extent to which social workers use theoretical models to guide their activities in concrete situations (DHSS, 1978).

A review of the social work literature was carried out in order to establish a list of transactions which have, at one time, been associated with social work practice. This review generated a large and

cumbersome list of transactions. The present list (see Figs. 4.1 and 4.2) was generated through a process of excluding those categories that were obviously redundant and combining similar types of transaction and placing them under a single, broad, heading. This method generated seven categories of social work transactions. During the interview the respondents were asked to describe the types of transactions they associated with social work practice. In the event that the respondent omitted a particular category on the list (s)he was asked to comment upon the social work claim to engage in that particular range of activities.

It was of some interest that both of the administrative grade social workers stated that they found questions about social work practice difficult to answer on the grounds that; a wide variety of transactions could occur between social workers and their clients; social work was, by its very nature, wide ranging and social workers had an extensive remit for practice; and social workers varied considerably, as individuals, in terms of their interests and abilities. The two administrative grade workers therefore chose not to answer questions which focused on the nature of social work practice.⁽¹⁾ In contrast to her superiors, the newly appointed attached worker prior to taking up her post did not hesitate to offer a picture of social work practice.

Perceptions of Local Authority Social Work Practice: Sustaining Functions

This refers to that aspect of practice where the social worker attempts to establish and develop an empathetic relationship with the client. At a functional level, this would include the social worker's skill at sympathetic listening, conveying interest in and concern for

FIGURE 4.1
GP Knowledge of Social Work Practice (Pre-attachment)

Doctor	Sustaining Functions	Didactic Functions	Provision of Material Aid/ Resources	Liaison Coordination	Supervision/ Social Control	Guidance Counselling	Socio-Psychological Therapy
Abel	+	+	+	+	+	+	
Baker	+	+	+	+			
Craig	+	+	+	+	+	+	+
Deans	+	+	+	+	+	+	+
Elder	+	+	+	+	+	+	+
Fair	+	+	+	+	+		
Health Centre							
B							
Gold	+	+	+	+	+	+	+
Hall	+	+	+	+	+	+	
Ivory	+	+	+	+			
Jones	+	+	+	+			
Kelly	+	+	+	+	+	+	+
Lamb	+	+	+	+			
McAdam	+	+	+	+			
Nelson	+	+	+	+	+	+	
Total	14	14	14	14	10	8	5

FIGURE 4.2

Health Centre Workers' Knowledge of Social Work Practice (Pre-attachment)

Health Centre A	Sustaining Functions	Didactic Functions	Provision of Material Aid/Resources	Liaison Coordination	Supervision/Social Control	Guidance Counselling	Socio-Psychological Therapy
Art (HV)	+	+	+	+	+	+	
Brown (HV)	+	+	+	+	+		
Curry (HV)	+	+	+	+	+	+	
Dollar (DN)	+	+	+	+	+		
Edge (DN)	+	+	+				
Flower (CPN)	+	+	+	+	+	+	+
Grant (CP)	+	+	+	+	+	+	+
Health Centre B							
Henry (HV)	+	+	+		+	+	
Innes (HV)	+	+	+	+	+	+	
Jade (HV)	+	+	+		+		
King (HV)	+	+	+	+	+		
Lite (DN)	+	+	+	+			
Miller (CPN)	+	+	+	+	+	+	+
Norton (HV)	+	+	+	+			
Osborn (HV)	+	+	+	+			
Park (HV)	+	+	+	+			
	16	16	16	13	11	7	3

the client, and encouraging and supporting the client in certain situations.

All of the participants expressed familiarity with the social worker's ability to provide sympathetic emotional support and encouragement to patients suffering from 'personal problems'. (See Figs. 4.1 and 4.2).

Dr Lamb: "If people present with personal problems the social worker can empathise with them and talk to them about the problem. So it's someone who is understanding and prepared to listen. It can give someone, under stress, relief to speak about the problem so long as there is trust and the knowledge that it goes no further".

Dr McAdam: "First is their listening skill, someone who will listen to the client's problems and, hopefully, find a way through the mass of problems to find some answers".

While the majority of medical and non-medical workers were familiar with this aspect of social work practice, and felt that the social worker's ability to provide the client with the opportunity to 'ventilate' or discuss his problems was of value, they did not regard this as an exercise in professional competence, judgment and skill. Nor did they conceive of this aspect of practice as a professional activity based on the social worker's training, experience and ability to apply, differentially, certain select forms of professional technique. Rather they regarded supportive work as the product of the social worker's humanitarian concern for individuals faced with difficult problems and as a function of the amount of time that she could make available to the client.

Dr Nelson: "In addition, they (social workers) offer the

patient straightforward sympathy and support. It isn't a skill, but it is important".

Dr Hall: "Perhaps it isn't a skill, or an area of expertise, but they can offer the patient their time. I think they have the ability to take time over a problem and offer their time over a longer period than, say the doctor".

Sister Dollar: "I think they'd be invaluable just to be there to listen to the patient; to give time to the patient so that the patient can talk".

Nurse Innes: "It's commonsense isn't it? The ability to relate to people easily and to give people confidence so that they can talk about their problems".

The participants also argued that the solution to certain problems did not require the application of the professional knowledge and skill of the worker, but were dependent on their personal qualities and life experience. Huntington (1981, p.32) argues that when personal qualities alone are regarded as important, the age of membership of social work and the marital status of its workers may be used as an expression of inter-occupational hostility and denigration⁽²⁾. It was not, therefore, surprising to find at least one health worker who observed:

Sister Edge: "I think that the social worker should be a more mature, married person with a great deal of experience. People who have their own homes and run them successfully. Someone who is able to sit down and listen to what is wrong".

The health workers' view of this aspect of social work practice may have been influenced by the nature of their own work. As Haugh (1976, 1978) and others (Horobin and McIntosh, 1977) have shown, the general practitioner, and perhaps the health visitor, has been used by patients as a general adviser on a wide range of non-medical matters although

they may lack expertise and training (Haugh, 1976, p.27). On the basis of their own clinical experience they may have come to regard 'listening and talking' as all that is necessary for patients presenting with a certain range of family and domestic difficulties (Ben-Sara, 1976).

This view of social work practice is in contrast to the way in which social workers might define their work, as one author notes:

The group of 'sustaining procedures' is inevitably a broad and varied category which includes some highly skilled work and more straightforward expressions of human warmth and concern ... The appropriate use of sustainment is at the core of all social casework, but it makes frequently exacting demands on the practitioners, calling for both sound diagnostic capacity and the ability to draw differentially on the various helping methods at their disposal. (Butrym, 1968, pp. 29-30).

The attached social worker therefore emphasised the expertise that was required to identify the best approach to take on a case by case basis and the skills that are required to investigate and assess the client's problem and to decide upon the most appropriate case management strategy which could include giving the client support. In addition she maintained that the ability of social workers to deal with problems of inter-personal relationships was predicated not on a simple common sense understanding of how people work, but on their training in various models of human behaviour, the 'dynamics of human interaction'.

Only the community psychologist offered a more sophisticated notion of this essential component of social work practice.

Ms Grant: "We have many people in the area who aren't coping very well with day-to-day living. They aren't coping with their financial problems, with kids,

with husbands on shift work. Many of them need a counsellor, someone to give them a jolt and to reassure them that they are coping. The social worker can offer them this kind of support while educating the patients, teaching them coping skills if you like. They seem to be skilled at interviewing and developing this kind of supportive relationship".

These perspectives and values highlight a problem which surfaced throughout the interviews. While the participants might have been aware, on a general level, of the types of transactions that could occur between social workers and their clients, they were unfamiliar with the exact form and content that such transactions might take.

Didactic Functions

Based on the social worker's substantive knowledge of welfare rights, the availability of different resource systems in the community, and the eligibility of different groups of clients for certain resources, this category refers to social work practice which takes the form of providing the client with factual information and advice about objects, events and resources.

According to the attached worker, social workers were able to act as an adviser to the client by providing concrete information.

Ms Bishop: "It isn't a (professional) skill so much as expertise. Social workers can offer clients practical knowledge about other agencies, facilities and benefits which they're entitled to".

The provision of factual information, particularly information to do with welfare rights and benefits was regarded by the majority, if not all, of the health care workers as the most important contribution that social workers could make to the care of the patient.

Nurse Art: "They can advise clients on what is available to them. It comes from their training; their knowledge of the rule book, the government rules on the rights of people".

Dr Baker: "The social workers have knowledge of the area (geographic); they know what groups exist, clubs, creches, coffee morning set-ups and the voluntary set-ups that are available in this area".

They were also familiar with the social worker's ability to provide information to the client about statutory services and welfare rights and benefits.

Dr Deans: "They have knowledge of the social work legislation and the 'aid' legislation especially social security benefits. So perhaps they can tell the patient, and the GP, what is within the law. Perhaps they can give patients information about their civil rights. It's quite disturbing how little young people know of civil law and where to seek help in civil cases".

For some of the health centre participants the social worker's ability to act as an 'adviser' could take a number of forms other than simply imparting information to the client. This activity could, in certain circumstances, take the form of direct intervention, with the social worker taking over the responsibility of deciding for the client how to deal with their problem.

Dr Abel: "An area of expertise is giving advice to the patient. Many patients that we see in general practice aren't in need of either medical or psychiatric care. Rather, they're poor managers, bad managers. The social worker is a great help by 'doing' the management of households, with immature couples especially and especially in crisis situations". (My emphasis)

Dr Hall: "Really they (social workers) may be dealing with

normal people who are at a crisis point in their lives. So the social worker can advise them, especially the dependents of the chronically sick and the handicapped, on how best to organise their lives in order to cope with the disability". (My emphasis)

A health visitor in Health Centre B stated:

Nurse Jade: "Well, I think that financial ineptitude leads to most of the problems that I put to them. Ineptitude of the patients or the bureaucracy. I don't see handicapped children, geriatrics and depression as their problem. It's really financial advice first and secondly social workers can help with equipment, e.g. bedding, aids".

As the comments above suggest, in certain instances the health service worker conceived of social workers as 'fixers', individuals who in the course of their encounters with certain clients, adopt a directive approach in order to solve a problem for the client rather than working with the client, to resolve the outstanding problem(s).

The attached worker reported that this category of social work—client transactions could range from simple advice on actual matters to more sophisticated forms of 'therapeutic' intervention.

Ms Bishop: "There is the fact of being an outsider; an objective listener who people can come to and get impartial advice that they may not be able to get within their circle of family and friends".

She then went on to add:

"Also, there's the expertise of being able to work therapeutically with an individual or family, based on our knowledge of the dynamics of interaction. It means being able to not only listen to the client but to explain what they are doing to themselves and to others. Say in a family situation where difficulties arise, you can see people individually and discuss how they feel about

the situation and what they have or haven't discussed with other members of the family. Then we can work towards open discussion with other members of the family so that they can come to a mutual understanding of the situation as they come to see the consequences of their handling of the situation".

Her conception of social work practice was again in stark contrast to the simplified understanding of didactic transactions held by the majority of health centre workers.

When they discussed the social workers' advisory role, two doctors (Dr Nelson, Dr Jones) and one of the community psychiatric nurses also made reference to a concept of 'entryism', those aspects of the professional's function which provided the rationale for his/her initial involvement in the lives of the patient/client. The three participants conceptualised their own involvement with the patient in terms of their ability to carry out certain basic routine functions. They felt that it was an unavoidable fact of general practice that they would have to engage in 'dirty work', treating acute minor complaints such as colds, minor injury and the like. As one GP graphically described it:

Dr Nelson: "I don't have any objection to the social workers extending their role, so long as they don't lose sight of the client's basic needs and so long as they don't try and avoid the dirty work. I don't mind getting my hands dirty, if you know what I mean, doing the work that has to be done. Take this morning, I did a rectal examination, I could think of far more interesting things to do than this. But, I view with suspicion if this kind of work is neglected for something more interesting, it means the basic needs of the patient are thereby neglected".

Mr Miller, a community psychiatric nurse, observed:

"I see them having a role in finance. It's a major headache and if they don't do something well then

they're doing themselves down ... if you can be seen to be doing something practical then you can go on to do the fancy bits. Once you have a foothold, once the patient trusts you".

From the point of view of the medical and non-medical workers, the social worker's ability to provide practical solutions to such concrete problems as financial hardship, housing problems and the like, served as a means of entry into the private lives and inter-personal relations of their clients.

Dr Jones: "One of the things we saw the social workers doing was taking a part in sorting out the problems of families with financial problems; assisting, advising and supporting the family ... I thought that this was their means of entry into the family with multiple problems, otherwise it's difficult to see where they would get an obvious entry into the family".

Moreover, once the social worker had identified her particular interests, medical workers also held the expectation that they would 'come up with the goods':

Nurse Innes: "They said to us that they wanted to be involved in the care of the terminally ill, in bereavement visits, in work with the handicapped and with children with personality problems. We went along with it, at least in one case, that was a laugh. Around Christmas, we had this guy with terminal cancer. He had four kids and was living in poor accommodation. Dr Nelson asked them to go in and do an assessment visit. At first they said 'yes' that they would try. Every time we had a meeting they either didn't know who the case was allocated to or the person to whom the patient was, finally, allocated wasn't there. Then the only thing they could offer was counselling at the area team; by this time the guy was bedridden. It would have been better if they had said that they would like to be involved in cases like this but that they didn't have the staff. Instead they try and bluff it through with the result that everyone ends up in a temper. They just haven't lived up to my expectations; they haven't delivered the goods".

Provision of Material Aid/Resources

This refers to contacts with the client that result in the social worker providing, or augmenting, their material resources. These resources may take the form of providing financial assistance and social resources such as the placement of children in foster homes, providing the elderly with Part IV accommodation, arranging holiday placements and the like. This particular aspect of social work practice was known to all of the participants and requires little further elaboration. However, there was a tendency, on the part of the participants, to overestimate the amount and extent of material resources that were available to social workers for their disposal.

All of the medical personnel placed great importance on the fact that social workers could provide concrete material aid to clients in need. Yet this was rated by the worker as the least important professional activity in which social workers could engage.

"Really these kinds of things are at the bottom of the list in terms of importance because apart from advice we have little access to actual money and material goods".

In common with the health centre respondents however, the attached worker saw no option but for the social worker to be involved in the provision of material goods and services when a case was defined as a 'crisis'.

"If confronted with the situation of a mother leaving her kids on their own there's not much you can do but intervene. Or, say the old person at the risk of malnutrition, or he sets himself on fire or he's dying of the cold. Then material

support, e.g. part IV accommodation, special payments are necessary".

Liaison/Coordination

This refers to the professional activities of the social worker whereby she acts either to link the client with various resource systems, or to link various resource systems with each other, e.g. linking the medical personnel with local authority social services. In such instances, the social worker may act as the 'conduit' through which information is passed and as a coordinator of services when two or more agencies are involved in the same case.

With the exception of one doctor, Dr Baker, and a district nurse, all of the participants expressed familiarity with this aspect of social work practice:

Dr Craig: "Social workers can act as the co-ordinating person between different agencies - liaising between different agencies".

Dr Lamb: "Social workers can fill the gap between different agencies. When there is trouble they can explore the family situation and when there is trouble with the law they can step in to try to maintain relations".

Health centre staff were especially appreciative of the ability of social workers to act as the patient's advocate in relation to a variety of bureaucratic institutions.

Nurse Osborn: "Often the social workers can act as the spokesperson for the client when the client is not very - when he or she comes up against authority. The social worker is the voice of the client really".

It was a generally held belief that on the basis of the social worker's knowledge of the voluntary and statutory agencies active within the community, their knowledge of how organisations worked etc., they could link the client with different agencies and institutions. On this point, the social worker agreed, stating:

"Social workers seem to have more contacts with other relevant departments; housing, social services, electricity boards and so on. I think that's something we've tried to build up".

However, with regard to the social worker acting as a spokesperson or advocate for the client, Ms Bishop offered certain qualifications which differentiated her ideas from the thinking of the health centre participants.

Ms Bishop: "Liaison is difficult - because by intervening with other departments we perpetuate a system where the individual members of the public can't get anything done which social workers can. If the likes of the S.S. are bombarded by members of the public they may be obliged to make changes. Whereas if the social worker does it, he'll smooth things over and, perhaps make things worse".

This broad political view of social work practice ran counter to the ideas and aims of medical personnel who, again, were more accustomed to taking a more directive approach in the lives of their patients and whose actions customarily took the form of doing something for the patient rather than something with the patient.

Supervision/Social Control

This is another area of social work practice which is the subject of much controversy and debate within the occupation. Supervision refers to the formal statutory and informal voluntary duties of social

workers to monitor the client so as to inhibit the emergence, or re-emergence, of particular patterns of client behaviour, e.g., the re-injury of children by their parents in cases of non-accidental injury, probationary after-care of ex-offenders and the supervision of the mentally handicapped in the community. At the same time they are meant to be offering the client their support. Although social workers, in common with other caring professions, might hesitate from conceptualising their work in terms of control, Prins and Whyte (1972) note:

"... social workers - unlike many doctors - have to accept that there is a 'social control' element in their functions by which we mean that they may be concerned with the enforcement of standards of behaviour and with expectations of the community with reference to conduct which fits the norm".

Ten of the doctors referred to this aspect of social work practice. As Dr Craig commented:

"The social worker can monitor the child at risk; frankly, I'd like it to be more than that; I'd like it to be so that it not only happened, but was seen by the patient to happen".

Two of the district nurses and the three recently qualified health visitors failed to specify this area as an aspect of social work practice. Again, the results from the interviews tended to indicate that staff had only a general idea of what transpired between social workers and clients in such transactions.

Sister Flower: "I think that they can monitor the situation more closely because of statutory agreements. That means a social worker is allocated to the case. Also the clients accept that the social worker has to be involved in regular contact".

Another health visitor, Nurse Innes, stated frankly:

"But, I don't know what they actually do with these problem families. It hasn't come out in my meetings with them how often they go in to visit and what it is that they do".

Nurse Innes: "They have power, particularly in Scotland, e.g. probation, supervision of N.A.I. (non-accidental injury) cases, etc. So, obviously I see their role as authoritarian because they have the power that we don't have. For instance, they have the power to take children into care, to arrange adoption".

The statutory powers given by the state to the social work profession appeared to be a source of some discontent amongst certain health visitors who gave the impression that they felt that the statutory powers accorded social work should also be a vested part of their own profession.

The social worker preferred to play down the social control element in social work practice while giving primacy to the caring element of social work practice.

Guidance/Counselling

Such transactions take the form of the social worker guiding the client along a course of action when two or more alternatives, or options, exist. They supply the client with details about the courses of action open to him/her so that he/she may make an informed choice of action from the different alternatives. This category would, therefore, include transactions in which the social worker 'worked through' the various options with the client, pointing out the likely outcomes and implications for the client who takes a particular course of action

prior to the action taking place, e.g. in the case of a pregnant, unwed teenager, looking at such alternatives as abortion, adoption, fostering and keeping the child.

While the directive approach to client counselling has come in for some criticism within and outside of the discipline (Butrym, 1968) this category includes those transactions which are designed to encourage the client to accept a particular, pre-selected, course of action.

Eight of the fourteen practitioners were, at the very least, familiar with this category of social work practice:

Dr Hall: "The thing that is good (about social workers) compared with ourselves is their ability to provide reflective counselling - not taking decisions for the client but rather presenting the problem back to the client in a constructive way. We tend to take decisions for the patient and we're not good at the other kind of counselling".

Dr Elder: "Social workers can present a gambit of choice to the individual, choices which centre on the immediate difficulty and encouraging them to take decisions while adopting what I would call a marginal position to that individual".

Less than half of the para-medical respondents expressed familiarity with this aspect of the social work task. Of the group of individuals who did allude to this area of practice, the health visitors emphasised the social worker's involvement in adoption counselling while the two psychiatric nurses and the community psychologist, emphasised the ability of social workers to counsel clients in general.

Ms Bishop saw 'counselling', as a fundamental part of social work practice.

Ms Bishop: "It covers a lot of areas. For example alcoholism. Alcoholism may well affect the couples functioning together and affect their children. So counselling clients is an important area to consider when talking about the services social workers provide. Or it may be in terms of more general marital problems. Again, an ability to be of assistance in the field comes from a knowledge and understanding of the dynamics of family situations through our training and experience".

Unlike the majority of medical staff who tended to conceptualise the social worker's approach in terms of 'directive intervention', guiding the client along a particular course of action, Ms Bishop again emphasised the underlying philosophy and values of social work practice which stress the importance of client self-determination in the social work--client relationship.

"If I had to generalise, I'd go for allowing people as much self-determination as was possible. That's usually total unless they suffer from mental illness or sub-normality etc. In situations where people come to the social worker and ask 'what shall I do', the preference is to give them alternatives and let them make their own choice. Although it can be directive in the sense of pointing out the consequences of their behaviour".

The social worker went on to mention, inadvertently, an aspect of social work practice which could, given the perceptions and attitudes of the health workers, fuel feelings of inter-professional rivalry and tension.

"Well, there are a lot of areas where the health visitor and social worker cover the same sort of problems, e.g. in advising and counselling mothers on child-rearing practices. But it comes to a point where the health visitors can't offer anything more where it's needed. Say there's an indication that the marital relationship is affecting mum's handling of the child. The health visitor might not see it as her remit to offer

advice and guidance on that level whereas social workers can and do. It could also involve difficulties in handling children or the child's reaction to the parent which affects the child's development".

Such thinking ran counter to the ideas of many of the health centre participants who looked to the social worker to 'fill gaps' in the services provided from the health centre, rather than duplicating their own efforts.

Socio-psychological Therapy

This area of social work practice is, by far, the most controversial and the subject of much debate within the social work profession (Bailey and Brake, 1975) and between social workers and other professional groups. It relates to the social worker's intervention in such problems as emotional deprivation, lack of social skills, psychological distress as well as problems to do with inter- and intrapersonal relationships. Intervention may take a number of forms, usually based on a psycho-dynamic model which falls short of psychotherapy (Prins and Whyte, 1972) and may include marital therapy, family therapy and the like.

Ms Bishop felt that the training and experience of social workers lead them naturally to become involved in psycho-therapeutic activities - a view which, again, ran counter to the beliefs of many health workers who defined this as part of medical work.

It is this category of social work practice which clearly differentiated the participants into two groups; those who were familiar with and accepted the psycho-dynamic aspects of social work practice and

those who either did not know or refused to accept this as part of social work practice.

Dr Gold; "I see the social worker as someone who has expert knowledge of family functioning; someone who is able to utilise the strengths of individuals and sees the family as a whole. Certainly they're involved with marital problems and problems of children within the family".

Dr Craig: "The social workers can be involved in family therapy at a variety of different levels. They deal not only with one member of the family, like the health visitor and the general practitioner, but with the whole lot".

While Nurse Innes, a health visitor, was aware of the claims made by social workers that part of their work involved a therapeutic element she found it difficult to accept such claims as a legitimate part of social work practice.

Nurse Innes: "I think that quite a large number of doctors and health visitors in general, and here too, feel that social workers don't have as much of a role to play in primary care as the social workers do. - Like social workers having a role in therapy groups. It's a specialised field and I personally think that there are other people about who are better qualified to do it".

This attitude towards the social worker's involvement in socio-psychological therapy was similarly expressed by the district nurse who stated:

Sister Lite: "When someone asked them what their role was and what problems they dealt with, the social workers said dealing with marital problems, the handicapped and bereavement. That wasn't my idea of them. Perhaps that's because specialised help is already available. We have specialised marriage guidance counsellors, psychiatric nurses and so on".

Statements made by the respondents highlight a number of issues salient to an understanding of the health centre workers' perspectives of social work practice. Firstly, many of the respondents' comments suggested that they engaged in a search activity when attempting to define what social work practice was or ought to be. That is they sought to identify gaps in the services provided by health workers and others while assessing how best these gaps could, or should, be filled by social workers. Thus, health workers defined the specialist area of knowledge of social workers as welfare rights, the law and welfare legislation, while highlighting the unmet needs of certain groups of clients:

Nurse Art: "Social workers could work much more closely with the handicapped, that area is neglected at the moment, nothing seems to be getting done".

Ms Grant: "An area that is not covered, and I feel strongly about, are the handicapped. The mentally handicapped school leavers and getting placements for them. There isn't anything for them and a campaign to develop and increase services is needed".

Secondly, it is of some importance that health service workers associated the field of socio-psychological therapy with practitioners in the medical domain. That is, therapy was thought to fall within the natural boundaries of medical practice with social workers seen as 'pretenders' to the medical throne when making claims to therapeutic expertise.

Unlike the majority of allied health workers, the members of staff directly involved in the provision of therapeutic services, the specialists in psychology and community psychiatric nursing, did see

therapy as part, or potentially a part, of the social worker's transactions with the client. As I have mentioned in an earlier chapter, their more liberal perspective of social work practice may be explained by the nature of psychiatric mandate which actively encourages various professional groups to participate in service provision and the experience of this group of workers with social workers in hospitals and other specialist settings.

Mr Miller: "My past experience with social workers in hospital ranged from the 'lady' almoner up to therapists in all sorts of psycho-dynamic fields, like groups".

II. THE ROLE OF THE ATTACHED WORKER

The participants were unanimous in their belief that the social worker had a proper and important role to play in the primary care setting. However, as might be expected from the data presented above, they varied in terms of their individual definitions of what constituted the attached social worker's role. Results from the interviews suggested that the participants could be differentiated into two broad ideological groups; those who held an 'extended' definition of the social worker's role (Dr Craig, Dr Elder, Dr Kelly, Dr Gold, Dr Deans, Sister Flower, Ms Grant and Mr Miller) and those who defined the social worker's role in more restricted, particularised, terms (Dr Abel, Dr Baker, Dr Fair, Dr Nelson, Dr Ivory, Dr Jones, Dr Lamb, Dr McAdam and the remaining para-medical workers).

Extended Role Definitions

This group of respondents maintained that it was up to the individual social worker to define her role for the benefit of those

already working in the primary care team. That is, it was the responsibility of the incumbent social worker to explain what she wanted to do, identify what patient/client groups she was interested in, and negotiate her role with individual members of the primary care team.

Dr Craig: "It's really up to her to decide what she wants to do; there is so much work that she could be doing. This involves her identifying her special interests really. She could make use of the psychiatric service and the psychology/paediatric services in the health centre. She could be involved in family and marital psycho-therapy, as it's a major problem in this catchment area".

Dr Craig then went on to warn:

"She has to be careful, however, not to take everything on; she must be critical of what she is doing and be critical of what she accepts. Her role really depends on her talents and how well she adapts to the health centre".

Dr Kelly: "It (the social worker's role) depends, to a certain extent, on what the social worker tells us she can do and what proportion of the patients the social worker is adequately equipped to deal with. We might find that she takes over an entire family from the doctors. But, if the social worker isn't confident in the 'medical role' when the patient expresses a medical problem, she might refer the case back to us, this is the way the community psychiatric nurse works".

Dr Gold: "I'd like to see the social worker use whatever expertise that she has - that's what happened with the previous worker. She had an interest in children's problems. I'd like to hear what skills and interests the social worker has. If she's interested in bereavement, marital therapy, etc. I'd encourage her to do it".

This 'liberal' view of the attached social worker's role was tempered, however, by the expectation amongst all of the doctors that:

- (i) the social worker would provide some evidence, presumably of a medico-clinical nature, of her ability. That is, the physician assumed the authority to evaluate, monitor and supervise the attached social worker;
- (ii) the general practitioner would exert some form of control over the social worker's case load; and,
- (iii) the doctor, in certain circumstances, would participate in the decision-making process regarding the management of particular patients/clients.

Dr Craig: "It (the social worker's role) really depends on her and what she wants to do and what her talents are. If she's of limited talent in certain areas then we can't allow her to function to the level where her limits are revealed to the patient". (My emphasis)

Another of Dr Craig's colleagues stated:

Dr Elder: "Her work can be carried out independently of the doctor but with his agreement and consent".

Restricted Role Definitions

This group of respondents tended to define the role of the attached social worker in less dynamic terms than their colleagues, placing certain limits on the types of problem they thought appropriate for a social worker to be involved with and by implication, limiting the field of the social worker's practice. On the basis of the interview data, it was possible to isolate two sub-groups within this category:

- (i) there were those who were unsure of what to expect from the attached worker as they were uncertain about the content and practice of social work; (Dr Jones, Dr Baker, Dr Fair, Dr

Lamb and Nurses Brown, Curry, Henry, Innes, Norton, Osborn, Park).

- (ii) there were others who spontaneously defined areas of work which they felt were not the province for social work intervention (Dr Nelson, Dr Ivory and Nurses Art, Dollar, Edge, Jade, King, Lite).

With respect to the former group and the question of the role of the attached social worker, Dr McAdam stated:

"Well, I haven't come up with any definitive answer yet. I don't think that it's entirely my own fault. I thought that social workers could help people with financial problems but they said 'no'. So, they don't do what I thought they did".

Dr Jones: "I think, at the moment, I'm not very sure what the social worker is or what my expectations are. One of the things we saw the social worker doing was to help sort out financial problems, assisting, advising and supporting the families having financial trouble. But we've been informed by them (area team social workers) that this is not part of their role".

A health visitor observed:

Nurse Innes: "I really don't know (what the social worker's role is/might be). At the meeting a fortnight ago I tried to get out of them what their role was and what it was they were doing. If they could say 'we can do this and this and this and not that because we don't have the resources' then it would have been easier. I don't know. I really don't know what they do".

In addition this group of respondents tended to emphasise some social work functions at the expense of others. Dr Abel, for example, saw a role for the social worker in 'supporting the recently bereaved';

however, this role was restricted to dealing with the practical, as opposed to socio-emotional, problems of the bereaved.

Dr Able: "The social worker can help by providing support to the bereaved - when someone is left alone suddenly, the social worker can advise them on the resources that are available; home help, meals on wheels etc. These areas didn't use to come under their control but they do now".

The latter group of participants were identified by their use of the 'negative' when discussing their expectations about the social worker's role. That is, they tended to define the role of the social worker by exclusion in terms of areas which they did not expect her to make a contribution.

Dr Ivory: "I see the social worker helping out in acute crisis situations. They (social workers) seem to think that they have a role to play in counselling the recently bereaved and also in marital problems; acting like marriage guidance counsellors. We, my colleagues and I, wouldn't see her in either of those roles. The patients are going to go to her for advice about how to manage certain crises that occur. That's woolly, I know, but I can't be more specific. Really my ideas aren't really clear".

Dr Able: "The social worker has a supportive role in inter-family relations; separating the ones who can be pulled together from the ones that should be separated; that's between the parent and the child, not the parents as that's the role of the guidance counsellor".

Again, value judgments were made about the importance of some aspects of social work practice to the work of the GP:

Thus, Dr McAdam noted:

"I feel that the (attached social worker) should find practical solutions to the social/medical

problems first and then, maybe, have something to contribute in her supportive role second".

He then went on to describe a case in point:

"I had a hospital report on a man who was beaten up by his wife, he entered hospital with multiple stab wounds. I had a note asking me what happened. The girl came in to see me and apparently the husband was going to throw her out and keep the little girl. She got angry, naturally, and grabbed the nearest thing at hand to stop him. That family will need re-housing and will also need support and perhaps practical advice on the financial aspects of separation, housing etc. ... I don't think that the 'Citizens' (Citizens' Advice Bureau) is a body to deal with that sort of thing".

It is noteworthy that the practitioner in this case emphasised the practical problems of this patient and not the problems of domestic order and inter- and intra-personal relationships and perceptions.

The Role of the Attached Social Worker in the Health Centre

While the participants varied in terms of the range of problems and professional activities they expected the social worker to deal with, they nevertheless held certain normative expectations about her role in the health centre setting (See Figs 4.3 and 4.4). They were of the opinion that they had a legitimate right to expect the worker to:

- (i) act as a 'sustaining agent' to patients and staff faced with difficult problems;
- (ii) act as an advisor, providing information on a wide range of practical issues; and
- (iii) in certain circumstances, act as the assessor and provider of basic material goods and services.

The Social Worker's Sustaining Role

All of the participants expected the social worker to provide patients with the time and opportunity to discuss their problems.

Dr Fair: "She can offer the patients her time so that they can talk, and she will listen to the patient's problems. This is of paramount importance in the health centre where the person doesn't get enough time".

Although the practitioners would, in certain circumstances, make adjustments to their own appointment systems by having the patient book double appointments to allow for more detailed discussion, they were nevertheless concerned with the restrictions imposed on patients by the 'six minute rule' for surgery consultations. Thus, as the above comment suggests, the doctors hoped to use the social worker as an adjunct to their practice and to compensate for the deficiencies in their practice. Indeed, some of the respondents felt that social workers could be differentiated from medical staff on the basis of the relationship they formed with the client as a result of their more flexible timetables.

Dr Baker: "The social worker can be set apart from the nurses and doctors, they can build up a friendly relationship with the patient and give advice and support on a daily basis".

Dr Jones: "The social worker is better placed than anyone else to support and keep people going. They tend to think in longer terms than we do. We know that physical problems are accompanied by psychological and social problems and therefore it seems to us to make sense that all of those dealing with the client should meet and operate from the health centre. Social workers have the time to get to know the patient and the family better than we do".

FIGURE 4.3

The Role of the Attached Social Worker: The GP's Viewpoint

Doctor	Sustaining Functions	Didactic Functions	Provision of Material Aid/Resources	Liaison Coordination	Supervision/Social Control	Guidance Counselling	Socio-Psychological Therapy	*Education	*Activist
Health Centre A									
Abel	+	+	+	+	+	+			
Baker	+	+	+		+				
Craig	+	+	+	+	+	+	+	+	+
Deans	+	+	+	+	+	+	+		
Elder	+	+	+	+	+	+	+	+	
Fair Health Centre B	+	+	+	+	+				
Gold	+	+	+	+	+	+	+		
Hall	+	+	+	+	+	+		+	
Ivory	+	+	+	+					
Jones	+	+	+	+	+			+	+
Kelly	+	+	+	+	+	+	+		
Lamb	+	+	+	+					
McAdam	+	+	+	+					
Nelson	+	+	+	+	+	+			
14	14	14	14	13	11	8	5	4	3

*Transactions associated with the attached social worker's role and not social work in general

FIGURE 4.4

Perspectives of the Attached Social Worker's Role amongst Attached Health Service Personnel

Health Centre	Sustaining Functions	Didactic Functions	Provision of Material Aid/Resources	Liaison Coordination	Supervision/Social Control	Guidance Counselling	Socio-Psychological Therapy	*Education	*Activist	
A										
Art (HV)	+	+	+	+	+	+				
Brown (HV)	+	+	+	+	+			+		
Curry (HV)	+	+	+	+	+	+		+		
Dollar (DN)	+	+	+	+	+			+		
Edge (DN)	+	+	+							
Flower (CPN)	+	+	+	+	+	+		+	+	
Grant (CP)	+	+	+	+	+	+	+	+	+	
Health Centre B										
Henry (HV)	+	+	+	+	+	+		+		
Innes (HV)	+	+	+	+	+	+		+		
Jade (HV)	+	+	+	+	+			+		
King (HV)	+	+	+	+	+			+		
Lite (DN)	+	+	+	+				+		
Miller (CPN)	+	+	+	+	+	+	+	+		
Norton (HV)	+	+	+	+					+	
Osborn (HV)	+	+	+	+					+	
Park (HV)	+	+	+	+					+	
		16	16	16	15	11	7	3	11	4

Nurse King: "We have such a large caseload we can't spend hours in a household. From what I gather they have fewer clients and can spend long periods of time with the family. They get to know the clients very well, even on a first name basis".

In addition, the participants anticipated that the social worker would offer support and encouragement to her co-workers in the primary care team:

Dr Nelson: "The other role of the social worker is, of course, in the team. Although you provide services to and have a primary responsibility to the patient, or client, they also have the responsibility to the mutual support of the team and its members".

Furthermore, participants expected that she would, on certain occasions, take on the responsibility for providing support to other members of the patient's family when the individual patient was undergoing treatment at the hands of the doctor:

Dr Elder: "She could help with alcoholics by supporting the family when the psychiatric nurse is dealing with the individual".

Finally, they thought that she would underwrite the advice given to the patient by her co-workers when they were involved with the same patient/client.

Dr Abel: "She could also support the health visitor by reinforcing what the health visitor has told the patient about hygiene, infant feeding, contraception and so on".

The attached social worker was seen by a minority of the health visitors as an extension of the health visiting service.

Nurse Art: "The roles (of health visitors and social workers) are confused. We should be in on the family before the social worker is in, and, hopefully, avoid the

social worker at all. She is the back-up service to us; it should never be the case that they know the family before we do"

Nurse Curry: "Well, she's somebody - the health visitor is between the nurse and the social worker. We can deal with problems so far and then they have to be referred to the social worker".

From the point of view of the health visitor, the attached social worker was expected to step in to resolve problems that went beyond the limitations of time, experience and professional ability of members of the nursing profession. This relationship was considered part of the preventative measures which could be carried out by primary care staff:

Nurse Osborn: "Well, when there's a fairly minor problem, when we begin to see marital strife, or the family needs counselling, a little assistance (from the social worker) might stop the lid from blowing off in the future".

The social worker and the senior social worker agreed that the attached worker could help fill certain gaps in the provision of health centre services, like the health centres workers, by offering patients the time to discuss outstanding problems.⁽³⁾

Ms Bishop: "The GPs don't have the time to discuss a patient's social problems in great detail. So, I see that as part of my role".

Further, she hoped, like the health visitors, that by being based in the health centre, the opportunity to engage in more preventative work would arise.

"Many problems are presented as medical problems to GPs and they aren't strictly that. If I can pick them up earlier rather than later, then they'll tend not to blow up to the same extent".

The Attached Social Worker as Advisor

The participants also held the mutual expectation that the social worker would provide practical advice and information to patients and staff on a variety of issues which included advice on financial matters. They expressed the concern that patients were not receiving all that they were entitled to receive:

Dr Abel: "By supportive I mean that the (attached) social worker should check if a patient has all of the correct benefits and allowances that are due to him".

Dr Lamb: "I see the attached social worker helping families with financial problems and helping people make the best possible use of the facilities and services that they are entitled to. Also helping patients to deal with crisis situations with regard to budgeting, especially when the gas and electricity are cut off and there are either young children in the family or old people with bronchitis - that sort of thing".

Again, in its most extreme form, the social worker was cast as the 'fixer' of problems.

Dr Jones: "Depending on her abilities, or skill, she can help in a practical way, those who can't handle their own lives. You know, those people who will never be able to deal with their own problems. She can just go in, from time to time, and sort things out for them".

The Attached Social Worker and the Provision of Material Aid

It was a universally held expectation that the attached social worker would, in certain circumstances, provide material resources to patients in need.

- Dr Nelson: "Um, I think that there is, firstly, a practical role for the social worker in that part of the social worker's task which is concerned with making adjustments to the patient's environment, e.g. in terms of finance ... I'd like her to be able, on occasion, to provide material help directly which could be in the form of money, or goods, furniture, blankets or even food".
- Dr Jones: "For the old person, who is unhappy at home, the social worker could enter into early discussion with those who live at home, on Part IV accommodation: something that is planned rather than treating it as a crisis".
- Dr Abel: "She could help arrange short-term foster parents, allowances; taking care of the financial side of things generally. Also, arrange for clothes allowances for indigents. She could supervise financial assistance for diabetics' foods and aids to these patients".

The Social Worker's Supervisory Role

The participants who declared an interest in having the social worker carry out a supervisory role saw this primarily in terms of her monitoring children at risk of non-accidental injury.

- Dr Jones: "In cases of post partum depression or baby battering the social worker could be involved with the long term follow-up and review of the case".

All of the staff, with the exception of two district nurses and the three recently qualified health visitors, anticipated that the attached worker would have a significant part to play in the 'monitoring' of families where the child(ren) was/were thought to be 'at risk' of neglect and/or non-accidental injury. In addition the two community psychiatric nurses and the community psychologist anticipated that the social worker would help supervise and 'keep an eye on' individuals who

had been released 'back into the community' from long-stay and short-stay psychiatric institutions.

The Attached Social Worker's Liaison/Coordinating Role

For the doctors, para-medical and non-medical staff of the two health centres, the attached social worker represented the person of first contact in matters relating to social work. In this capacity, the social worker was expected to link the health centre with a variety of different resource systems.

Dr Elder: "The social worker could link, in a fashion, us with statutory agencies and link us with the Social Work Department locally.... Liaising with these agencies on the basis of decisions taken between the social worker, the general practitioner and, for example, the psychiatric services".

Nurse Park: "Ah, she should have the knowledge of what financial benefits are due a client, how housing is allocated and how housing priorities work in cases of house transfers. It's her liaison role with the 'New Town' Development Corporation and her relation to other bodies as a whole which I think is important".

In relation to the local social work department one health visitor expressed the hope that the attached social worker would act as their "agent" within the area team, passing on information that otherwise might come to light.

Nurse Jade: "I don't know if she'll have access to the records in the area team. I hope that she does. Perhaps she could get more information for us by having access to (social work) moves that we don't have. She could then pass this information on".

One doctor went on to suggest that with the appointment of the social worker the opportunity would be created to link the health centre with

agencies with whom they previously had little contact.

Dr Craig: "Maybe, in fact if she's interested, she could go to see the elderly and act as a link to other agencies who are not very involved with the health centre side; I'm thinking of Age Concern or some others".

They also hoped that as a result of these linkages being developed the patient would benefit not simply from the intervention of one or more different agencies, but from 'planned intervention' whereby the various parts of the health and welfare network would act in concert.

The social worker was also expected to pass on the worries, fears and anxieties of health centre staff to the social work department.

Dr Hall: "I expect the social worker to liaise with the area team, passing information and our anxieties back and forth".

Huntington (1981), reports similar findings. She found that general practitioners do not care to refer patients to, and make contact with, large scale bureaucratic organisations, preferring personal contacts with individual workers. He therefore sees the attached social worker as his personal mediator and interpreter between himself and agencies external to his practice.

In common with the health centre participants, the three social work respondents anticipated that the social worker would play an active role linking the health centres with the local Social Work Department.

Ms Argent: "Also she'll have the ability to relate to the primary care team and to act as the link between us and the various other professions".

Mr Carson: "I'd say that she certainly has a role as liaison

person and contact person between the doctors and the social work department".

The attached worker also accepted that she would serve the interests of the medical staff by acting as the person of first contact in the referral process.

"From my experience in the Local Area Offices I noted that GPs do make a lot of referrals which could be dealt with more quickly if they were referred to the social worker in the health centre rather than having to go through the allocation procedure in the social work department. ... They won't have to go through the process of getting help from the Department which can be a lengthy and unfruitful process. A social worker here might help the autonomy of the place".

Unlike the health service workers, the social worker anticipated that she might also have a role to play as a go-between between the doctor and the patient.

Ms Bishop: "Um, the (attached) social worker might have a role to present a patient's case to the doctor where the patient and the social worker thought that the case wasn't being handled in the right way".

The Attached Social Worker's Role in Guidance and Counselling

Eight of the fourteen doctors made some reference to the attached social worker having a part to play in the guidance and counselling of patients who attended their specialist clinics. Those doctors who specialised in obstetrics and gynaecology or paediatric medicine anticipated that the social worker would provide guidance and counselling to unwed mothers (Drs Abel, Craig, Deans, Nelson). Those who specialised in child and adult psychiatry (Drs Elder, Gold, Kelly) hoped that the social worker would prove to be a useful co-worker in

their work with families with a known history of alcohol abuse.

Only seven of the sixteen health service workers expected the attached worker to act as a guidance counsellor to selected members of the patient population. All of the respondents who were in some way connected with the provision of psychiatric and psychological services, the two community psychiatric nurses and the attached community psychologist, felt that the attached worker could help counsel parents faced with child rearing difficulties and patients, and their families, with a history of alcohol abuse.

The Social Worker as Therapist

The social worker anticipated that she would carry out all of the functions outlined above. In addition she expressed the view that she would have an active part to play in the provision of psycho-therapeutic services existent in the two centres. Like the medical staff who comprised the centre's psychiatric team, the social worker assumed that she might be called on to work as a co-therapist with either the doctor or other members of the psychiatric team.

"A social worker in this setting is appropriate as a co-therapist if the doctor thought that two people working together with a family or couple was necessary on marital and sexual problems".

"I could work as a co-therapist with Sister Flower and Mr Miller. We cover the same sorts of areas on many occasions and in particular I'd say working with alcoholics. Alcoholism isn't strictly a medical problem".

The three practitioners whose speciality interest was in psychiatry and two of the paediatrician/general practitioners thought that the

social worker would have a complementary role to play in the area of socio-psychiatric therapy, as did the two psychiatric nurses:

Dr Elder: "I see her involved in marital therapy with either myself or the community psychiatric nurse. It's likely that she could be involved with alcoholics, treating either the individual or taking the marital approach to problem drinking".

Mr Miller: "I see myself benefiting most (than other health centre workers) from the attachment. I can see myself getting more help from the social worker and more involvement because our work overlaps".

Anticipating that the attached social worker would be a female, the psychiatric nurse in Health Centre B stated:

Mr Miller: "I'd like to have a working relationship (with the social worker) in all sorts of cases. For example, I need a co-therapist in marital cases and in six therapy groups that are going on in the centre. It depends on her skill and experience - sorry. I have a picture of a female social worker; you can't offer counselling to couples unless there is a male and female counsellor".

It is of some interest that those who expected the social worker to assume a 'therapeutic' role did so in the belief that the social worker would act as a co-therapist rather than a therapist in her own right. A number of factors may account for this.

Firstly, as Dr Elder's comments suggest, although the participants were aware that the social worker's training, methods of practice and theoretical orientations differed from their own, they appeared to be uncertain about the content of social work theory and method.

Dr Hall: "It's difficult to know what the social worker's role would be (in the psychiatric services) because the psychiatric nurse is already dealing with the psychologically disturbed and the chronic

psychiatric cases. It's done from the point of view of psychology and psychiatry rather than from a sociological point of view. Perhaps she will be asked to become involved with the rest of the family".

By acting as a co-therapist the social worker could be observed by the doctor, carrying out her therapeutic functions.

Secondly, as I have mentioned earlier in this chapter, all of the doctors expected to assume control over the attached social worker. By acting as a co-therapist the social worker would be placed under the doctor's authority. As one doctor commented:

Dr Craig: "We'll have to watch that she doesn't open a can of worms before she has explored the problem and discussed it with the Principal. Frankly, I don't know how much training they get in psychology or how in-depth and clinically oriented it is".

Another GP observed:

Dr Deans: "While in favour of experienced social workers doing counselling I have my doubts about recently qualified social workers becoming involved in this area. If they do, they must also have a good deal of supervision".

Thirdly, the doctors emphasised planned intervention. The social worker acting as co-therapist would allow the doctor to collaborate with the social worker in developing a common treatment policy for the management of the patient.

Finally, the attached social worker was of value to practitioners and staff who required a female co-therapist in order to carry out certain specialist functions, i.e. the sexual dysfunction clinic required both a male and female therapist. The social worker therefore filled a

gap in service and served the interests of those who wished to develop and maintain these services in the health centre setting.

Such expectations of the social worker's role appeared to be highly influenced by their experience of working with social workers in the hospital setting.

Sister Flower: "The other thing is that social workers, especially in the hospital, are involved with counselling patients jointly with other professionals and I don't see why that couldn't happen here. I could see myself working with the social worker doing therapy at some time".

Not all of the participants welcomed the idea of the social worker as therapist. Dr Nelson commented before the social worker took up her appointment:

"The psychiatric nurse does a good deal of counselling and psycho-therapy and while it's important for the social worker to be aware and sympathetic to the emotional problems of the client I would think that it would be desirable to avoid excessive duplication of counselling in the psycho-therapeutic services ... I'm very wary of one client being counselled by more than one person, although close liaison is important".

Some of the health service workers did not regard the social worker's practice as something complementary to the existing psychiatric services, but as an unnecessary, and wasteful, duplication of effort.

A small minority of participants ascribed two additional functions to the attached social worker which they did not associate with social work in general, they anticipated that the attached social worker would act as an activist and educator.

The Social Worker as Activist

Three of the doctors (Doctors Craig, Jones and Baker) and four of the health service workers, Ms Grant and the three recently qualified health visitors, Nurses Norton, Osborn and Park, speculated that the social worker could have an activist role within the health centre. Firstly, the social worker could act as investigator, and lobbyist, for new services:

Dr Craig: "Another aspect (of the social worker's role) is the research component. We have a rough idea of the social work component of all jobs, but, we don't have in-depth knowledge of all of the social determinants of the problems that we see in general practice. She could look at what happens in (New Town). I think that there are micro-communities; streets in the town that are affected by one or two families. They're like 'pockets of illness'. She could develop a monitoring record system, academic links and cooperate with outside bodies to tell us 'this is what's making the community behave this way'. This might have a beneficial spin-off in that such information could be used to put pressure on the regional authorities for more resources".

Dr Jones: "The social worker might find out about the resources that are available in the community and about the specific needs of people in the community, i.e. the mum who is about to break down because she needs to get out of the house. She could organise these mums into a self-help group based in the health centre - or anywhere else for that matter".

Nurse Osborn: "I just thought, it would be good for the social worker to get things organised to provide day care nurseries for working mums, for kids, deprived kids and handicapped kids. Also she could provide support groups for single parents. There's nothing being done at the moment. I see it as part of good social work service when they initiate self help groups".

Aside from the direct benefit to the client, two of the health

visitors went on to suggest that the setting up and operation of self-help schemes would provide them with an opportunity to work together and contribute to their growth in mutual understanding.

Nurse Park: "Again, going back to self help groups. If there were, say, a house or a hall where families could meet and could be put in touch with the social worker and the health visitor, I think that I would find it a good place for the two to get to know and liaise with each other".

The theme of the social worker acting to investigate problems and mobilise resources was similarly emphasised by two doctors who expressed concern about the plight of battered women. In this case the social worker was to mobilise resources in the health centre and the community:

Dr Baker: "She could also investigate the battered wives phenomena. Once she knew the families, or once she had identified the families, she could alert us to the problem. We'd then be in a position to have, ah, to see if they were medically at risk".

The attached worker also anticipated that in addition to working with individual clients and/or their families, she might also extend the centre's services by engaging in group work.

Ms Bishop: "I could be involved in clinics and groups, for example, setting up an alcoholic group. I can see that this would be a good idea to have a group focusing on alcohol problems, in a place like this. It's a good way of using oneself as a resource and using the strength of individuals in the community.

The Social Worker as Educator

All of the health centre staff freely admitted to having little idea about the nature and content of social work practice.

Mr Miller: "I've worked with social workers in a number of different settings but it doesn't make it any easier to express what I know or what I think I know about them".

. Therefore, eleven of the sixteen respondents looked forward to the social worker explaining the role of the social worker in general and the role of the attached social worker in particular.

Nurse Brown: "I think another part of her role is communicating to other disciplines what her role is ... it's someone to go to that's got a different training and background. She'll see things differently - it's a different way of looking at the person".

Ms Grant: "We can get guidance about the appropriateness of referrals and save the social work department from our unrealistic aims. We'll learn what is and what isn't possible for the social worker to do. We might also be able to learn about the pressures on the social work department. I know that the pressures are pretty severe but we don't take these into account. Also, they should learn something about the pressures that are on the GPs".

In addition, the social worker was expected to advise and inform the medical staff about a wide range of issues associated with the resources that were available to social workers and legislation surrounding the provision of these resources.

Dr Jones: "She has an educational role to play; educating us about the use of resources and the social work department and the function of the social worker. However, the important thing is her expertise in telling us what is available and whether we're making proper use of these services".

Nurse Brown: "Hopefully I'll get up to date information on legal aspects and financial benefits - she'd be a resource person. It's someone we'd be able to ask about the legal rights of people, whether the thing to do is go through her or go up to the CAB, that sort of thing".

Mr Miller: "We get all of these pamphlets and the social worker could interpret this information for us. With the information at her finger tips it could save me quite a lot of work".

Four of the doctors were open to the social worker offering them a new way of seeing problems commonly encountered in general practice.

Dr Elder: "She could provide some teaching within the health centre, or information, in relation to the assessment of individual problems e.g. social problems which are presented as psychological problems. She could also educate us to use the social services appropriately. Broadly speaking, she might, just might, broaden the GP's horizons, perhaps, and introduce a new perspective into the management of patients and their problems".

Dr Hall: "She could offer a new slant on what's normal and what are realistic expectations that we should have for certain families - she could offer, ah, provide a different perspective about a problem - providing a more analytical appraisal of situations".

Dr Fair: "It's specific areas of knowledge that I'm lacking in. It's very difficult to define. Um, there are some awful problems that are recurrent and another person throwing a different light, or approaching the problem from a different angle, would be very helpful".

The subject of educating staff about different ways of seeing and interpreting common problems was given particular emphasis by the other non-medical specialist in the health centre, the community psychologist:

Ms Grant: "The main thing that any non-medical person has to offer is a new way of looking at problems, aside from the purely medical perspective. Also imparting knowledge of what is available and what is appropriate to patients i.e. when a GP says 'take the kid into care' without knowing the effect on the child or the family. This type of thing needs to be taught and passed on to others".

One practitioner, Dr Elder, expressed the hope that this would lead

to better social background reports on their patients.

Dr Elder: "The social workers have skills in dealing with family problems and the effect of these problems on their interactions. The compilation of a family profile might be of great use to the GP who is often dealing with isolated members of the family. In that sense the social worker has a 'changing role' and an educational role. A changing role for the family and an educational role for the GP".

For one doctor, however, the social worker's educational role was not confined to the health centre. Dr Craig suggested that the social worker could, like a number of her medical colleagues, become involved in health education in settings other than the health centre:

"She could go into the schools and talk about family problems so that the kids wouldn't have to learn about these through bitter experience. Also she could talk a bit about her job so that they knew where to come when they did have problems".

It is interesting to note that in comparison to the general practitioners, only four of whom anticipated that the attached social worker would have an educational role to play, the majority of the paramedical and non-medical workers both expected and looked forward to the social worker carrying out an educational function within the health centre.

In common with the general aims and goals of the attachment, all three social work respondents and their executive officers felt that the attached social worker had an important role to play educating medical staff about social work and social work practice.

Ms Argent: "I think the (attached worker's) role - it's a difficult task - is to be educative about the sort of things we can do while developing their understanding of what can and cannot be done".

Mr Carson: "I'd say, from the doctor's point of view an attached social worker can give advice and information about her own limits and where they can get additional advice".

Ms Bishop: "I think that I'll have an educative role with the health visitors, the district nurses and the GPs in terms of letting them know what we are doing, what's available and how things are looked at in a slightly different manner".

Certainly there was a desire on the part of the social workers to educate medical personnel away from the stereotyped models that they had of the social worker as the 'fixer' of practical and material problems and the 'financial expert'. It was intended that the medical staff would, by means of the attachment and the efforts of the social worker, develop an understanding of social work practice which closely approximated the ideas and ideals of the social workers themselves. It was of note, however, that at no time in the interview was reference made to the social worker educating social workers about medical practitioners and medical practice. A number of comments made by many social workers suggested that they held an equally simplified view of the doctor, labelling him as a 'pill pusher', and the attached health centre workers as 'handmaidens' to the physicians:

Mr Carson: "On the attached social worker's side there is a danger that doctors begin to use the social worker in an inappropriate way and see her as something like the health visitor, someone to arrange transportation for the patient to hospital and doing other labouring jobs that the social worker feels someone else should provide".

It is unlikely that nursing staff, whatever their specialty, would either conceive of their work as 'labouring' or appreciate those who perceived of their efforts in this way. The respondents gave the

impression that social workers too could benefit from a better understanding of the role of the health care worker and primary care itself.

Both the attached social worker and the senior were of the opinion that she could also offer medical staff an alternative, 'social work' perspective:

Mr Carson: "I think that the attached social worker is basically carrying part of this department into the health centre. The social worker will have different training and experience. She'll be able to offer a social work perspective as opposed to the physical-diagnostic training of the doctor".

Aside from offering a new diagnostic framework for identifying and defining the problems encountered in general practice, the attached worker also looked forward to the opportunity of the participants' new ideas about case management for patient care.

Ms Bishop: "I think that I could offer a different perspective - in terms of handling the patient".

The Role of the Social Worker as Team Member

As I have reported in the previous chapter the social worker was expected to contribute to and participate in the professional and social life of both health centres; by attending meetings, participating in social functions, and generally involving herself in the daily rituals and routines of the medical setting.

Health service staff held certain general expectations about the role of the attached social worker as a 'team member'. In general they hoped that the attached worker would respond to the needs of the health

centre staff and their patients rather than the institutional and professional demands associated with the social work department.

Nurse Henry: "I'd like her to visit people rather than say to me 'the case can't be allocated' or 'it isn't a priority'. I'd like her to visit the patient if I'm particularly worried".

Nurse Art: "I'd like her to be available, on the spot, to consult if a crisis develops. To be near to give advice or to take action if it's needed".

Dr McAdam: "If the health visitor is looking for practical solutions, I think that the social worker should go along with that rather than rejecting it out of hand. I think that's reasonable. The social worker has got to help where she can even if she doesn't think it's part of her role. She has to be prepared to get her hands dirty without selling herself short. Only by working together will they find out about each other's skills".

This perception of the social worker's role may lead to a number of difficulties. Ratoff and his colleagues (1974) found that the failure to understand the social worker's role may lead medical practitioners to use her as a 'sophisticated secretary' or to dump in her lap those cases which take up a large part of his time, e.g. neurotics and those with personality disorders.

However, in relation to the two health centres under discussion it is necessary to qualify Ratoff's warning about the 'dumping' of patients on the social worker. Observation of the participants at work revealed that they had developed an informal system of patient management which relied not on dumping the patient in another worker's lap, rather patients with intractable problems were 'bounced' between various members of staff. For example, the community psychiatric nurse, the health visitor or another practitioner might be called on to take over

responsibility of a case, for an unspecified period of time, in order to give their colleague a break from the demands made by this type of patient. This was done with the knowledge that the patient could, or would, be referred back to the principal at any time.

This relationship between doctors and attached staff was conceived as part of the system of mutual support within both of the centres. It was therefore not surprising that this reciprocal arrangement of work-sharing was an expected feature of the attached social worker's role.

Dr Hall: " ... she should take on her share of the insoluble problems and to that extent help her colleagues. Some families always require attention and this helps relieve other members of the team from the responsibility. This is done in the knowledge that they can always refer the patient back".

Dr Nelson: "The other role of the social worker is, of course, to be an integral member of the team. They also have a responsibility to the mutual support of the team and its members,. It might manifest itself in a number of ways; it may mean meeting with colleagues to form and adopt a common policy about the patient and generally being prepared to live and work together and assist one another with the caseload".

Staff also had clear-cut ideas about the form that their contact with the social worker should take. The health service workers emphasised the need for face-to-face contact with the attached social worker.

Nurse Henry: "I'd expect an informal role - e.g. to meet with her in the corridor and tell her that I have a family that I'm worried about and I want to know their rights in a particular area. I don't want a drawn out referral - just information ... I expect her to impart information on services and benefits in an informal way even if I'm not actually referring the case".

With respect to the social worker's involvement in the activities of the health centre and the formation of personal relationships with the staff:

Dr Kelly: "this won't work if she is seeing people who have been referred and then goes away again. It wouldn't be much more use than (the area team). Unless she takes part in the team meeting the advantages of having an attachment will fade away".

Dr Gold: "I'd like to see the social worker enter into the social huddle of the health centre; chatting to the secretaries, coming to the Christmas party. If she does that then there will be no problems in terms of working relations. ... I'd like to see - when we do have a meeting on Friday or Wednesday of the psychiatric team - I'd like to see the social worker involved and contributing; joining in and being part of the health centre. Being interested, offering advice and taking on cases. Not someone who sits and waits to be asked. If that happens the attachment will be a success".

Bargaining Power and the Negotiated Order

The interviews and discussions with the health service workers about the attached social worker's role yielded some useful insights into the division of labour and the power relationships within the health centres.

In the first chapter I drew attention to the fact that the medical workers, particularly the health visitors, were concerned when the area team social workers made claims to knowledge and expertise in fields of work which they found particularly interesting and professionally rewarding; counselling the bereaved and dealing with the physically handicapped and their families. While the health centre participants regarded this area of work as part of the 'medical domain' they were aware that it was a relatively ill-defined and unstable territory, where

no single occupational group could state categorically that they had the legitimate right to practise. Rather it was an area that was subject to much dispute, claim and counter-claim between different occupational groups.

The health visitors were particularly vocal in respect to challenging the social workers' right to practise in these areas and regarded the social work claims as 'encroachment' into their domain. This reflected the relative insecurity of the health visitors who had only just begun to work routinely with the bereaved, having negotiated their role and having established their 'working credentials' with the doctors to practise in this area. This arrangement with the doctors is informal and therefore open to change. It is within the power of the general practitioner to channel certain groups of patients, or certain types of problem, away from one group and into the hands of the other. In the event that the doctor can be persuaded by another occupational group, social work, that their abilities and skills are equal to or better than those of the health worker, the position of the subordinate worker is jeopardised.

Some health visitors felt especially vulnerable to the claims made by the social workers on the grounds that they saw their own claims as an expansion on their part into 'social issues'. They feared that there would be reprisal on the part of the social workers in the form of 'boundary busting' into the territory which the health visitors had only recently occupied and now regarded as falling within their jurisdiction.

This conflict tells us much about the relationship between GPs and social workers and the power relationships between physicians and para-

medical staff in the health centres. All of the para-medical workers were dependent, to a greater or lesser extent , on the doctor for the referral of interesting cases.

Dingwall (1977, 1980) argues that health visitors maintain some degree of independence and autonomy from the GP because they have an independent responsibility for primary prevention among a demographically defined population:

They are the only significant group of nurses with direct access to clients rather than depending upon the selection of the medical profession. (p.91)

Another way of stating this proposition is to say that certain groups of para-medical workers, in this case health visitors, are given a certain amount of independence from the doctor, and are able to exercise a certain degree of autonomy over their working situation because they have options in case-finding. It is the fact that the health visitor has alternatives, that she has a choice other than to rely on the doctor for case-finding, which diminishes or restricts the power and influence of the doctor over the health visitor. However, the ability of the para-medical worker to maintain their independence from medical control is mediated, in the concrete setting of the health centre, by the agreements she reaches with the doctor. If she is committed to the outcome of negotiations with the doctor and accommodates the doctor, in order to work with a select body of patients, the bereaved and the physically handicapped, she will be unwilling to see changes to her agreement with the doctor. In this way the para-medical worker subordinates herself to the doctor and comes under his control.

The introduction of a social worker into the setting represented a challenge to the para-medical workers in the form of another subordinate member of staff who was competing for the same pool of interesting cases.

For example, during a conversation with a clinical psychologist who held weekly clinics in Health Centre B, she commented:

"On the whole I think the health centres and the psychiatric team will benefit from having an attached social worker. But, I'd fight if I found that all of the interesting cases that I've had from Dr Hall were being passed on to her instead of me. I definitely wouldn't accept that. It's taken me a long time - about a year - to educate the doctors about my work here, about the contribution I can make. I still get the occasional inappropriate referral from Dr Lamb and I have no intention of seeing all of the interesting cases being passed on to someone else".

This quote shows and displays the way subordinates in the health centre depend on referrals from the doctor and not from outside agencies. Power and influence in the health centre setting was related to, at least in some measure, the ability of the parties to manipulate and restrict access to sources of rewards which are valued by the other party. The social worker was viewed by some as a competitor for the largesse distributed by the doctor.

A different version of this theme is found in the comments made by a community psychiatric nurse one month after the start of the attachment programme. At this point the attached social worker attended a meeting in Health Centre A when she described her specialist interests and outlined some of her ideas for the development of the post. Following the meeting the attached community psychiatric nurse returned

to her office looking tense and angry. When asked what had disturbed her she replied;

"Well, I was really surprised when Jane (the social worker) said that she was interested in becoming involved with counselling alcoholics. I didn't expect her to say that - it's an area that I'm already involved in and as I see it there would be a lot of overlap. At the moment most of the doctors know that I'm interested in working with these patients and they refer patients directly to me. But if the social worker's going to be involved it's just going to cause a lot of unnecessary confusion. You know 'do I refer the patient to the social worker or the psychiatric nurse?' That sort of thing. I was going to ask her to explain how she saw her involvement, but I didn't - I thought that someone else would bring it up, I thought Dr Elder would bring it up, but he didn't. No one else seemed too concerned, so I thought there's no point. Maybe it's me, maybe I'm just paranoid and there aren't going to be any problems".

Here the community psychiatric nurse felt unable to defend the definition of her role because it required the doctor, in the first instance, to recognise her role and jurisdiction. The nurses and lay workers appeared to defer to the authority of the doctor because of their position in the authority hierarchy or their attachment to certain occupational interests and goals.

Informal controls were developed through a process of negotiation and accommodation between health centre workers which facilitated a minimal level of co-existence on a daily basis. The introduction of the social worker into the centre makes a difference to the existing social order not simply because she may compete for work but because she intervenes in the relationship between medical and para-medical workers. That is, she upsets the accommodation that subordinate staff had reached with the doctors.

Certainly the lower level participants were aware of the fragility and the temporality of the negotiated agreements they had reached with the physicians and they felt insecure that the fine balance of agreement would be altered with the introduction of the social worker into the medical setting. The social worker was, in their eyes, a new and unknown quantity who could have a dramatic impact on the existing order.

The assumption by Strauss et al (1964) that all of the parties to an agreement are of equal power to change, modify, or cancel an agreement is questionable when applied to the health centre.. Certainly this is true to an extent; however, Strauss seems to ignore the fact that para-medical staff may have to spend a good deal of time and effort bringing the doctors to the point where they will negotiate and then negotiating an agreement which is to the satisfaction of the para-medical worker. In other words the para-medical workers had to 'work' at developing their negotiating position. Further, depending upon the importance they placed on the outcomes of their negotiations with the physicians, para-medical staff were interested in and motivated to maintain the existing agreements. The issue was, at least for them, not that any party to the agreement had the power and opportunity to revise or revoke the agreement but that the physician might unilaterally make that decision. Like Goldie (1977), I would argue;

The ability of (physicians) to prevent lay staff from having access to certain patients is regarded as an example of their 'objective' power".

He goes on to argue:

His power is actually seen as restrictive and limiting, though it will depend on the

sort of contract the staff wish to have with the patients which may be quite limited".

The acceptance of rewards, such as the referral of interesting cases, results in a situation where the threat of their withdrawal transforms the power of the physician from power by inducement to that of power by coercion.

In this instance it can be argued that the preparedness of physicians to negotiate with staff and to relinquish responsibility, or partial responsibility, for the care of certain patient groups does not simply reinforce their dominance over subordinate groups (Eaton and Webb, 1979) but actively helps to extend it by adding a new dimension to the power relationship. For example the power of the physician may be derived from their ability to control the flow of patients to the paramedical worker. This type of power relationship may be transformed into a relationship which includes a coercive element when the subordinate begins to fear that his own interests are in jeopardy. This point is made by Blau (1964) and Giddens (1968). Blau argues:

regular rewards make recipients dependent on the supplier and subject to his power, since they engender expectations that make discontinuation punishment. (p. 117)

Giddens observes:

Inducements offering some definite rewards in exchange for compliance always offer the possibility of being transformed into negative sanctions; the withholding of reward represents a punishment and represents a definite form of coercion. (p.266)

The power of the doctor in the health centre and his influence over

para-medical staff rests not simply upon his legitimate and competent authority then but is based upon a web of combinations and inter-relations of different types of power.

Indeed the doctor need not actively threaten to withhold the cherished objects or things, for example channeling patients with drink problems from the community psychiatric nurse to the social worker, for as Wrong (1981) argues, the subordinate simply must know or believe that the super-ordinate actor actually possesses the resources and that there is a reasonable probability of his using them to wield power should the actions or the inactions of the subordinate fail to accord with what they take to be his wishes. In such situations we can say that the physicians' power is in repose; that it is latent but effective in ordering the work of the subordinate.

Further, according to Mechanic (1967) low status workers may exert considerable power and influence over superiors if the services of the low status workers are difficult to obtain: the scarcer the resources the greater the probability that they will be able to define the conditions of their work and the more influence they have to bring to bear in the bargaining situation. The introduction of a social worker who makes claims to having the same or better knowledge, skills and expertise to deal with similar types of work to that of other subordinate workers may weaken their bargaining position by diluting their claim to possess scarce resources.

It is, perhaps, for this reason that many of the participants, including some of the physicians, consistently defined throughout the interviews the social workers' role in terms of the gaps she could fill

in the existing system of service delivery.

Ms Grant: "The role of the social worker - Oh yes I didn't include anything about child care and separation. Broadly speaking mums going into hospital, children going into care. Separation is an area that no-one feels is their role and I feel it should be the social workers' role".

On one level this emphasis on filling gaps serves a certain functional purpose within the service delivery system by catering for the unmet needs of the patient population. In addition, by focusing upon the provision of services which heretofore have not been provided by the participants or provided on an ad hoc basis the para-medical and medical staff avoided the risk of having the social worker as a competitor for a particular jurisdiction or domain.

The attachment of the social worker to the health centre can therefore be seen as an intrusion of social work into the 'medical domain' dominated by the doctor and where the social worker has to find a place amongst competing dominated groups.

SUMMARY

In this chapter, I have sought to establish a review of the participants' knowledge of social work practice and to describe their expectations about the role of the attached social worker in the primary care team. These data indicate that the majority, if not all, of the participants were familiar with those aspects of social work practice concerned with the provision of concrete help to clients, i.e. offering support to the client, providing the client with information and advice and supplying material aid.⁽⁴⁾ While all of the participants were familiar with the more straightforward, instrumental transactions that could occur between the social worker and his or her client, health service workers also anticipated that the attached social worker would have an instrumental role to play within the primary care team. They anticipated that she would offer support to patients and health service staff and provide both groups with information and advice on welfare rights and benefits. Throughout the interviews the participants expressed the hope that the social worker would fill gaps in the already extensive services provided from the health centres. The social worker was expected to fill these gaps by fulfilling a practical role within the primary care team - especially in relation to problems of financial and material hardship.

One might speculate that the participants over-emphasised the practical activities of social workers, at the expense of other areas of practice, as a result of their training. As I have noted in an earlier chapter, doctors and para-medical workers are trained to take action, of one form or another, when presented with a problem. In addition, their training places emphasis on monitoring the outcome of their management

decisions. It is possible that problems of a practical nature are more readily identified by health service workers and the action of social workers in response to these practical problems would be observable to the participants. That is action may be seen to take place, and the participants could in such cases see the results of the social worker's intervention, e.g. debts being cleared, arrangements made to deduct pay at source.

Despite the general consensus of opinion about the social worker's practical role, the participants varied considerably in terms of their knowledge and expectations about the 'emotional work' content of the social worker's role. They could be differentiated into two groups on the basis of their knowledge about and expectations of the social worker acting as a psycho-therapist.

I would argue that their preparedness to accept the social worker's claims to competence in this area of work, their expectations about the role of the attached worker acting as a co-therapist and their knowledge of social work practice in the psycho-dynamic field, was significantly affected by their specialist interests. It was by no means coincidental that the participants who accepted the premise that the social worker had a role to play in the delivery of psycho-therapeutic services practised psychiatry (adult and child), paediatrics, or geriatrics. As Goldie (1977) and Dingwall (1980) have observed, it is within these three specialities, along with general medicine, that the holistic version of medicine has most clearly emerged. It is within these specialities where the social, psychological, emotional, and physical aspects of patient care 'inter-penetrate'. It can, therefore, be argued

that these specialist practitioners were ideologically committed to and aware of the social worker's potential contribution to the development of socio-psychological and socio-emotional work within the centres. While the participants practising these specialisms may not have felt comfortable outlining the various underlying values, orientations and perspectives employed by social workers on a day to day basis, they were, at least, aware of the fact that the social work frame of reference differed markedly from their own. Perhaps for this reason rather than seeing the social worker duplicating the work carried out by others in the health centre, this group of participants viewed social work practice as something qualitatively different, and therefore complementary to their own pursuits. This model of social work practice would undoubtedly find favour with the majority of social workers.

This perception of social work is in contrast to the other group of practitioners whose views are captured in Dr Jones' observation that:

"I get the impression that everyone comes down on one area, a small area, so that we get three or four people involved - all doing the same thing. This could lead to a clash of interests between the GP, health visitor and the social worker so that we don't know where we stand".

These findings suggest that the participants' perception of the role of the attached social worker was influenced by a variety of factors other than their knowledge of social work practice including their perception of the needs of patients; their views on what gaps existed in the services provided by the health centre team, and ideological orientations associated with particular medical specialisms, as well as their stock of knowledge about social work practice. These

findings have a number of important implications for the social worker taking up an attached post.

Once in post, the range of activities that the social worker could engage in may be quite extensive in comparison to other, similar, appointments in other settings. As one GP/paediatrician commented:

Dr Deans: "It's difficult to know how to get her involved. There are two ways really. We could get her involved in the GP side of things so that she is responsible for all cases that we refer or we could take it by specialty interests. For example, my own interest is with children so maybe she could get a foothold there. I wouldn't see her attending all of the paediatric clinics, it might be boring for her, but it would be appropriate to make specific referrals as problems come up".

The conjoint appointments of the doctors may have the effect of providing the social worker with a rich source of material for practice and a variety of different entries into the practice life of the centre. Conversely, the social worker might also be faced with a barrage of referrals from doctors operating at two different levels, as generalist and specialist. Given that the participants varied in the way they perceived the role of the attached social worker, the incumbent could be faced with the problem of role conflict. For example, while her involvement in cases of bereavement may be acceptable to some of the general practitioners, these expectations are incompatible with the ideas and beliefs held by others. Many of the para-medical workers were particularly concerned that the attached social worker would challenge their recently won 'right' to deal with cases which they defined as clinically interesting and professionally rewarding.

Only four physicians (Drs Craig, Elder, Jones and Hall) anticipated

that the social worker would act as an educator, educating medical staff about the nature and principles of social work and welfare rights, and introduce them to a new way of seeing problems from a 'sociological' perspective. Unlike the general practitioners, over half of the health service workers expected the social worker to have an educational role within the centres; educating the members of the primary care team about social work in general and the nature and practice of the attached worker in particular; instructing them on welfare legislation and benefits and explicating the social work perspective on common problems.

The area team leader and the senior social worker preferred not to answer questions about social work practice. The attached worker's description of social work practice corresponded in many ways to the perspectives of social work held by the health centre participants. While she did not regard the more instrumental and practical activities of social workers, such as advice giving and making provision for material aid and adaptations, as priority areas of practice she nevertheless felt that they would be a legitimate part of her practice within the health centre.

The attached worker and the social work officers differed from the majority of health centre participants in terms of their perspective of other important features of the attached social worker's role. The social workers anticipated that the attached worker would act as an educator of health centre staff about social work practice. Only a small number of primary medical care staff expected the social worker to carry out this function. It was interesting to note that the social workers did not mention an educational function for the attached social worker within the Department despite evidence which shows that the

social workers might have benefited from a more precise and detailed understanding of the nature of primary medical care and the role of the various health care practitioners.

The two groups also differed in terms of their expectations about the social worker acting as counsellor and as a co-therapist with members of the psychiatric team. A minority of the health centre participants considered such activities a legitimate part of the attached worker's role.

The health centre participants hoped to engage a worker who would take an active part, on her own initiative, in the social and professional life of the centre. The social worker was to have a commitment not only to the patient/client but in addition to members of staff operating from the health centre setting. Each group expected the social worker to take an active part in the affairs of the health centre and become a 'fully-integrated member of the primary care team'. Given that the post was to be split between the two health centres, this could act as a source of strain for the social worker attempting to satisfy the expectations of all concerned.

In contrast to this the senior social worker and the area team leader emphasised the attached social worker's role as a member of the social work department. The social worker was faced with the prospect of the two health centres and the area team competing for her time and services as a scarce resource.

The issue of the social worker's collegial role with the primary care team takes on special significance in the light of the social worker's expectations about her practice role within the primary care

team. For example, in order for her either to attempt to direct the health service workers along new pathways in patient management or to challenge, with the patient, the doctors' management decisions, her collegial role relationships would necessarily have to have been highly developed. That is, many of her patient-oriented role expectations were predicated, according to the participants, on the social worker successfully integrating into both the clinical and non-clinical routines of the health centre and her forming close personal ties with those with whom she worked.

It was a normative expectation amongst all of the physicians that once the attached social worker was in post that she would come under their authority. They assumed that they had the 'right' to control her workload by playing a positive part in the selection of cases she was to deal with; that they would, as a matter of course, evaluate her performance; and, that she would structure her work around the practice routines of the medical practitioner. This conflicted with the equally paternalistic assumptions of the social worker's superiors who held the belief that they had to 'protect' the attached worker from any unreasonable demands placed upon her by the physicians. The attached social worker therefore risked being caught in the middle of a conflict between the two groups of authority figures who engaged in a battle for power and influence over the worker and the helm which steered the course of development of the attachment programme. The various conflicts outlined above represent key decision issues which had to be addressed by the various parties. The outcome of their deliberations will, it is argued, give insight into the nature of the power relations within the health centre setting.

CHAPTER FIVE

THE PATIENTS, THEIR PROBLEMS AND THE PROCESS OF REFERRAL

The investigation of the flow of patients from one practitioner to another has yielded some useful insights into the social organisation of patient care, the structure of medical practice and the specialist workers' inter-professional relationships (Van de Ven et al, 1979; Rawensky and Loudan, 1962; Williams and Clare, 1979). Various studies of the referral of patients have also cast light on the networks along which a patient must pass in order to receive specialist treatment (Shephard et al, 1966; Rickards et al, 1976, Corney and Briscoe, 1977; Corney and Bowman, 1980; Fahy, 1974; Kaeser and Cooper, 1971).

This chapter is an account of the referral process in the health centres over three two-month enumeration periods. Some of the questions which I address include; what kinds of patients were referred to the social worker; how was the referral obtained; what was the source of the referral; what was the reason for referral and; what was the role of the social worker in respect to the patients she interviewed.

An Additional Note on Methodology

The study had the objective of collecting data on the interactions which occurred between the social worker and the referral agent. Interactions between the social worker and the referral agents were divided into two groups; in-group interactions and out-group interactions. In-group interactions were those which involved the worker and her health centre colleagues whilst out-group interactions were those which occurred between the social worker and people from

outside the centres. The study focusses exclusively upon in-group interactions.

The data consisted in the first instance of a written report from the social worker who was asked to complete a form as each referral was made (see Appendix B). The social worker was asked to record:

- (i) the reason, or reasons given by the referral agent for making the referral;
- (ii) the problems that the social worker identified during her initial assessment interview with the patient and;
- (iii) the action or actions undertaken in light of her assessment.

When the forms were collected the social worker was interviewed in order to clarify and amplify the documented material. These data were up-dated over a period of up to eight weeks.

Once identified the referral agent was interviewed in order to establish;

- (i) the reason(s) they had given the social worker for making the referral;
- (ii) their expectations of the social worker's role;
- (iii) their knowledge of the social worker's activities in response to the referral and;
- (iv) their satisfaction with the social worker's performance.

With regard to items 3 and 4, the referral agent was followed up

for a period of up to eight weeks. Thus an independent report of the interaction was obtained from each of the participants. The two responses were then matched in order to determine the extent of mutual reporting; mutual reporting was said to occur when both parties identified and reported the same factor(s). Unilateral reporting was said to occur when only one of the parties identified and reported a factor(s).

An indicator of mutual reporting was constructed by taking the sum of mutually and unilaterally reported factors (N) and calculating the proportion of mutually reported factors. This figure is then converted to and presented as a percentage of the total number of reported factors.

The design, based on ex post facto reports from the participants, clearly introduces the factor of selective recall; certain issues may be forgotten or perceived as too unimportant to record. In addition the design was susceptible to the participants providing post hoc rationalisations in their accounts of their behaviour. To reduce the effect of selective recall and to maximise the chances of mutual reporting these data were supplemented by two additional sources of information; field notes and documents. The researcher was able to observe and record the details of a number of their interactions as informal referrals were made. The participants were then questioned on the issues outlined above. All written material, referral letters and the social worker's entries into the medical records, were examined and analysed.

The Number of Patients Referred

A total of 97 cases were referred to the social worker over the three enumeration periods.

Table 1:

Number of Patients Referred to the Attached Social Worker by Health Centre

Period	Health Centre A	Health Centre B
	Number	Number
Jan-Feb	24	16
June-July	7	14
Nov-Dec	23	13
	54 (55.7%)	43 (44.3%)

This figure does not represent the total number of patients who were either referred by the referral agents or interviewed by the social worker. In a number of instances it was clear that the patient who was referred (the primary referral) was used by medical staff as a means of getting services to other family members (the secondary referral). In addition the social worker frequently interviewed members of the patient's family who in turn became part of the client system.

While the flow of patients in Health Centre B remained relatively stable over the three enumeration periods referrals in Health Centre A tended to fluctuate.

What is of particular interest here are the figures for the third enumeration period, November to December.

At this stage in the attachment programme the social worker, acting on the advice of her senior social worker, unilaterally called for a complete moratorium on referrals; centre staff were advised to direct all social work referrals to the local social work department or some other appropriate external agency. It was argued in a formal letter that she circularised that this was to give her a 'breathing space' to catch up on the serious backlog of work which had accumulated over the first ten months of practice. The figures clearly show that her request was, by and large, ignored by the participants.

The interviews with the referral agents during this period revealed that for some of the practitioners the continued referral of patients to the attached worker demonstrated their complete rejection of her request. This conflict was particularly acute in Health Centre A. Many of the participants, particularly the doctors, expressed the view that the centre had already come a poor second place to Health Centre B in the division of the social worker's time and that her request represented yet another penalty that they did not wish to pay. Further the way in which the social worker and her senior took this decision unilaterally in the absence of any discussion or negotiation with the participants, increased the tension in an already strained relationship between the attached worker and her health centre colleagues. From their point of view the request lacked legitimacy and was simply 'not on'.

The doctors' control over the flow of patients to the social worker, and hence her work rate, and the fact that the social worker actively picked up many of the cases rather than referring them to the area team, demonstrated, to an extent, the objective power of the doctor

over the subordinate worker.

Age/Sex Distribution

The age and sex distribution of social work patients is shown in Table 2.

Table 2 : Age/Sex Distribution of Referrals

	<u>Health Centre A</u>				<u>Health Centre B</u>			
	<u>Male</u>		<u>Female</u>		<u>Male</u>		<u>Female</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
00-14	1	1.9	5	9.3	1	2.3	2	4.7
15-19	1	1.9	6	11.1	0	0	1	2.3
20-24	0	0	8	14.8	1	2.3	5	11.6
25-44	8	14.8	13	24.1	3	7	20	46.5
45-59	0	0	2	3.7	0	0	5	11.6
60-64	1	1.9	0	0	0	0	0	0
65-74	1	1.9	5	9.3	0	0	1	2.3
75+	1	1.9	2	3.7	0	0	4	9.3
	13	24.1	41	75.9	5	11.6	38	88.4

Both groups were principally composed of young adult and middle-aged patients. Patients under the age of 15 and over the age of 60 were generally under-represented. Two factors may go some way to explain this trend; firstly the age distribution of the groups may simply reflect the demographic characteristics of a Scottish new town with a concentration of inhabitants who are of employable age. Secondly both

centres had attached health visitors and district nurses who dealt respectively with the very young and the elderly.

Women predominated in all of the age groups. Female referral rates were over three times male rates in Health Centre A and seven times the male rates in Health Centre B. As the rate of female attendances to the centres' surgeries and clinics was higher than that of males the female patients were more vulnerable to referral than their male counterparts. Further, in a small number of cases women were used as a vehicle for the delivery of services to other members of the household, i.e. the husband, children and elderly relatives. The participants also said that they referred more women than men as the social worker was a woman. It was part of their general management strategy to refer patients they thought would feel more comfortable discussing their problems with a female member of staff. This might also explain the difference in sex distribution between the two centres; in Health Centre A the physicians had both a female community psychiatric nurse and community psychologist to whom they could refer their female patients.

Marital Status and Household Composition

Table 3 shows that there were slight differences between the two groups in terms of their marital status.

Table 3 : Marital Status by Age of Social Work Clients

Age Group	Health Centre A				Health Centre B			
	S	M/CoH	W	Div/Sep	S	M/CoH	W	Div/Sep
	no. %	no. %	no. %	no. %	no. %	no. %	no. %	no. %
15-24	10 (18.5)	4 (7.4)	0 (0)	2 (3.7)	3 (7)	3 (7)	0 (0)	1 (2.3)
25-44	0 (0)	13 (24)	0 (0)	8 (14.8)	2 (4.7)	7 (16.3)	0 (0)	14 (32.7)
46-64	0 (0)	3 (5.6)	0 (0)	1 (1.9)	0 (0)	3 (7)	1 (2.3)	1 (2.3)
65-74	0 (0)	1 (1.9)	5 (9.3)	0 (0)	0 (0)	0 (0)	1 (2.3)	0 (0)
75+	0 (0)	0 (0)	2 (3.7)	0 (0)	1 (2.3)	0 (0)	4 (9.3)	0 (0)

10 (18.5) 21 (38.9) 7 (13) 11 (20.4) 6 (14) 13 (30.2) 6 (14) 16 (37.2)

The main differences are that in Health Centre A, married cohabiting patients were the largest category (39%) with only 20% separated or divorced, whereas in Health Centre B, the largest category was that of divorced or separated people (37%), with only 30% married cohabiting.

Table 4: Household Composition of Social Work Clients

Composition of Household	Health Centre A		Health Centre B	
	Number	%	Number	%
Living alone	13	24	12	27.9
Married couple	4	7.4	1	2.3
Married couple with children	18	33.3	14	32.6
One adult with children	15	27.8	15	34.9
Other household with two or more adults with children	1	1.9	1	2.3
Other household with two or more adults	3	5.6	0	0
	54	100	43	100

There were no significant differences with respect to household composition.

Social Class

The occupation of the patient, or in the case of married/cohabiting women the occupation of their spouse/cohabitee placed the majority in the Registrar General's Social Classes III - IV. (Table 5)

Table 5: Socio-Economic Composition of Social Work Clients

Socio-Economic Group	Health Centre A		Health Centre B	
	Number	%	Number	%
I	1	(1.9)	0	(0)
II	5	(9.3)	3	(7)
III	9	(16.7)	15	(34.9)
IV	8	(14.8)	10	(23.3)
V	20	(37)	13	(3.2)
Not known	11	(20.4)	2	(4.7)
	54	100	43	100

Patients whose occupations placed them in the professional and managerial categories Social Class I and II, were under-represented. Again there were slight differences between the two groups. 37% of the patients referred to the social worker in Health Centre A were designated Social Class V, whereas a larger proportion of patients were assigned to Social Class III, 35% in Health Centre B. Such differences reflect the social class distribution of patients living in the two districts, or catchment areas, served by the two health centres.

Source of Referral

The physicians were the single most important source of referrals to the social worker (Table 6).

Table 6 : Referral Agents

Referral Agent	Health Centre A		Health Centre B	
	Number	%	Number	%
General Practitioner	26	(48.1)	24	(55.8)
Health Visitor	13	(24.1)	10	(23.2)
District Nurse	3	(5.6)	1	(2.3)
Community Psy. Nurse	0	(0)	1	(2.3)
Community Psychologist	1	(1.9)	N/A	N/A
Other H.C. Worker	5	(9.3)	0	(0)
Client Self Referral	3	(5.6)	3	(7)
Friends/Relatives	0	(0)	1	(2.3)
Local Authority Agency	2	(3.7)	0	(0)
Other Agency	1	(1.9)	3	(7)
	54	100	43	100

The first group of doctors referred 48% of the cases to the social worker while their colleagues in Health Centre B were responsible for 56% of the referrals. The health visitors proved to be an important secondary source of referrals through their role as "problem-finders" in the community and in the families they visited. Referrals from the other participants, the community psychiatric nurses, district nurses, midwives and the community psychologist were relatively few and far between, although Health Centre A personnel were slightly more active in

the referral process than their counterparts in Centre B. In common with previous studies of attachment schemes (Corney and Briscoe, 1980) external agencies were not an important source of referrals to the attached social worker.

Method of Referral

The social worker was asked to record the method employed by the referral agent to bring the case to her attention. Most of the referrals (62%), in both health centres were made during the course of informal face-to-face discussions in the hallways, coffee rooms and reception areas of the centres (Table 7).

Table 7: Method of Referral

<u>Method</u>	<u>Health Centre A</u>		<u>Health Centre B</u>	
	<u>Number</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>
Standardised form	3	(5.6)	0	(0)
Formal letter of referral	14	(25.9)	4	(9.3)
Note	1	(1.9)	1	(2.3)
Verbal face to face	33	(61.1)	27	(62.8)
Telephone	3	(5.6)	3	(7)
via intermediary	0	(0)	8	(18.6)

The participants obviously did take advantage of what they considered to be one of the most fundamental advantages of attachment - informal, personal contact with the individual worker. There were however marked differences between the two groups in their choice of secondary methods of communication. Thirty-one per cent of the referrals in Health Centre A were by formal letter. The choice of this

mode of communication stemmed initially from a normative rule established by the community psychologist prior to the arrival of the social worker. In order to keep track of her referrals the community psychologist requested that all referrals should be made in written form. This rule was simply applied to the social worker when she joined the practice. During the latter stages of the attachment, however, participants who had at one time relied upon more informal methods of communication began to use a referral letter: as I will show later in this chapter the social worker tended not to keep the referral agent informed of her activities once the referral had been made. The use of formal methods of communication provided the participants with a written statement of the date and reason for referral to which they could refer in their encounters with the social worker at a later stage.

Reason for Referral

I asked the health centre staff why they referred the patient to the social worker, their 'Reasons for Referral'. I then asked the social worker what reasons had been given by the referral agent for making the referral, the 'Social Worker's Perception of the Reason for Referral'. I then asked the social worker for her own interpretation of the patient's presenting problem, the 'Social Worker's Assessment of the Patient's Problem'. These three aspects of the referral process are tabulated in Tables 8 and -. Table 8 compares for each health centre the reasons given by the referral agent for making the referral and the social worker's interpretation of the reason for referral. Table 9 by contrast shows the social worker's perception of the patient's problem. Taken together this gives us three views of the

social work referral.

Previous studies of social work attachments recommend that guidelines for the selection of patients for referral should be established before the social worker takes up his or her post. Such guidelines other than the more general requirement that all referrals to the worker should have a 'medical component', were never established. ~(1) Nor did the attached worker construct a priority list once she had joined the practice. As a result medical staff were given a great deal of latitude with respect to the types of referral they could make.

Table 8 shows that the participants tended to refer patients with multiple problems, some of which were long standing and intractable. In over two thirds of the cases material and practical problems were cited as the primary reason for referral by the referral agent. It is of note that in many instances the participants' interest in having the social worker address the material and practical difficulties of the patient was perceived as a modus operandi for introducing the worker into the family, and her reason for entry into the domestic life of the patient. This was particularly important in cases where either the patient or the family were judged to be resistant to the idea of social work intervention: for example, a young married couple were referred to the social worker ostensibly to help with their financial difficulties. The doctor went on to note:

Dr Fair:

"First it was advice on finances. But I didn't think that it was just for that. From there (she) could have become involved in looking at the ramifications to the family of Mr Coulson's continuing unemployment and discuss any marital difficulties they might have. Which, I suspect, are present in this family".

Approximately 31% of the patients referred to the social worker were said by the referral agent to be experiencing some kind of family or domestic difficulty; about 17% were diagnosed as having a physical illness, including terminal illness (cancer), acute illness (threatened miscarriage, hypertension); progressive illness associated with old age, and handicap (Down's Syndrome); and a large proportion of the patients were diagnosed as mentally ill or handicapped, "personality disorders", alcoholism, depression and so on. The doctors in Health Centre B referred a slightly higher proportion of patients defined as suffering from problems of mental health, 53%, than their Health Centre A counterparts, 35%.

Medical staff were particularly concerned with the social ramifications of physical and mental ill-health on the patient and their family. In the case of progressive and chronic illness or handicap the participants expressed interest in the social worker establishing, at an early stage, a relationship with the patient/family who was likely to require long term advice and support.

Another clinical factor which influenced the participants' referral behaviour was the observed stress displayed by the patient in consultation with the health worker. Patients who were 'emotionally charged and very upset' by their domestic situation were referred to the social worker for advice and support. The decision to involve the social worker was based on what the health care worker saw as a purely technical judgement. By that I mean they saw the issue as merely a matter of fact, based upon the ability of the referral agent to: observe clinical facts (that which is objective); identify and define

the nature and locus of the patient's presenting problem; and to apply their skills in light of these facts. The decision to refer the patient was also based upon certain non-technical considerations which involved the agent making judgments about "what should be done" in light of certain values (that which is subjective). For example, two elderly patients were referred to the social worker on the grounds that they were "nice old ladies who really deserve a holiday". Value judgments played a particularly important part in the agent's decision to refer cases which involved young children thought to be 'at risk'. In such cases medical personnel clearly thought that "the children should be removed from the home for their protection". Value judgments were also evident in cases which the referral agent judged to be of only marginal professional interest; cases which could be defined as a "social work problem" were defined as a social work problem.

Nurse Art:

"The district nurse, who had cared for the grandmother, referred the case to me because she thought something should be done about the child. I handed her over to the social worker, I didn't know if the grandmother had custody or whether the mother still had legal rights, but it wasn't within my remit at all. Because I had no interest in the case and there was nothing I could do it was a social work problem. Anyway, it was the day before I started my holiday so I didn't have the time to look into it".

Table 8 : Reason for Referral Reported by Referral Agent and Social Worker

	<u>Health Centre A*</u>			<u>Health Centre B*</u>		
	<u>Referral Agent</u>		<u>S.W.</u>	<u>Referral Agent</u>		<u>S.W.</u>
	<u>No.</u>	<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>	<u>No.</u> <u>%</u>
Material/Practical Problems	38 (79)	29	(60.4)	31 (86)	23	(63.)
Legal difficulties	-	-		-		-
Family Relationship problems/child care problems	16 (33.3)	9	(18.8)	14 (38.)	7	(19.4)
Social Relationship problems/soc. isolation)	3 (6.3)	1	(2.1)	3 (8.3)	0	(0)
Problems of work/school	3 (6.3)	0	(0)	2 (5.7)	0	(0)
Child at risk/NAI	7 (14.6)	5	(10.4)	1 (2.8)	1	(2.8)
Underage/unwanted pregnancies	5 (10.4)	4	(8.3)	2 (5.6)	2	(5.7)
Physical disability/ill health	9 (18.8)	3	(6.3)	6 (16.8)	2	(5.7)
Mental illness/personality problems	9 (18.8)	5	(10.4)	9 (25.0)	2	(5.6)
Mental handicap	2 (4.2)	3	(6.3)	5 (13.9)	2	(5.6)
Problem drinking/drug abuse	6 (12.5)	4	(8.3)	5 (13.)	2	(5.6)
Other	10 (20.8)	6	(12.5)	16 (44.4)	4	(11.1)

*N = 48

**N = 36

Another factor which influenced the decision-making process had to do with the administrative arrangements for patient care in the two centres. Patients were instructed to register as families with an individual practitioner who was then, ideally, responsible for the medical needs of the whole family. This system of registration offered the physician the opportunity to build up an extensive and detailed picture of the patient and their family circumstances. However, this system of patient registration was not unproblematical. In some cases different members of the family offered the physician conflicting views of their circumstances. The doctor then felt placed in a position where his or her loyalty was divided. On such occasions the social worker could be called upon to offer an alternative source of consultation to one of the family members. As one doctor commented:

Dr Hall: "Another reason why I referred the case was that I didn't want to split the family up. As I said, I see Mr Johnson regularly and he talks to me about his own problems. If Mrs Johnson wanted to express negative feelings about her husband I felt that she would find it easier to do it with someone who was not seeing Mr Johnson".

It was clear that the participants' extensive knowledge of the patient's clinical and social history influenced their decision to refer the patient to the social worker.

Precisely how their stock of knowledge about the patient affected their decision to involve the social worker is not clear. It is conceivable that in some instances they referred those patients with a known history of personal and relationship difficulties. They may, on the other hand, have regarded some problems as continuous until such time that the problem had been resolved through treatment or the

intervention of another specialist. Alternatively patients with a long history of social disruption may simply have been labelled 'problem patients' or 'problem families' therefore making them prone to referral to a social worker.

Turning to the extent of agreement between the social worker and the referral agents over the reasons for the referral, Table 8 shows that in Health Centre A 61% of the factors associated with the referrals were mutually reported by both participants. In Health Centre B the proportion of mutually reported factors was 48%.

In general the referral agents provided the social worker with a full and detailed account of their reason(s) for bringing the patient to her attention, although on occasion they would shorten and simplify their explanation. There was in addition a marked tendency amongst the participants to emphasise those aspects of the case which they thought were particularly relevant to a social work referral. In this way they were able to justify the referral on rational grounds.

Dr Ivory: "It's often difficult to know whether or not to refer the case to the social worker or the psychiatric nurse. Sometimes I don't know who should be involved. I've had that happen a few times - usually I wouldn't have referred a case like this to the social worker. - I felt that it wasn't particularly a social work problem as there was a long standing alcohol problem to sort out. But as there were financial difficulties I thought the social worker should be involved".

On certain occasions it was clearly not in the referral agent's interest to reveal all of his reasons for referring the patient, for example cases which were deemed of little professional interest. Yet the participants were in the main very frank and did not substantially

alter the original input which influenced their referral behaviour.

Direct observation of many of the referral episodes and analysis of the referral reports revealed a marked tendency on the part of the social worker to take the complex wealth of information she received and highlight certain features of the participants' accounts and ignore others. This reductionist process enabled the social worker to make sense of the information and determine a starting point for her first contact with the patient. As a result each referral event contained a different meaning for each of the participants. The social worker also ran the risk of either undervaluing or misapprehending the referral agent's reason(s) for bringing the case to her attention.

Problems identified by the social worker

The problems that the social worker identified at her initial interview with the patient were similar in each group. (Table 9)

Table 9 : Social Worker's Assessment of the Patient's Problem(s)

Problem	Health Centre A		Health Centre B	
	<u>Number</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>
Material/practical	34	(70.8)	29	(69.4)
Legal	-	-	-	-
Family relationship	24	(50)	15	(41.7)
Social relationship	8	(16.7)	5	(13.9)
Work/School	2	(4.2)	0	(0)
Child at risk	0	(0)	0	(0)
Unwanted pregnancy	5	(10.5)	2	(5.6)
Physical disability	6	(12.5)	6	(16.7)
Mental illness	9	(18.8)	9	(25.0)
Mental handicap	2	(4.2)	1	(2.5)
Drug abuse/ problem drinking	6	(12.5)	3	(8.3)
Other	8	(16.7)	8	(22.2)
Total:	104		78	

Among the social problems recognised by the attached worker were a high proportion, 70%, of material and practical ones (housing problems, financial difficulties, employment problems). The social worker also uncovered many problems related to family and domestic difficulties particularly marital conflict.

Perhaps surprisingly, a relatively small number of patients were judged to have problems of physical ill health or disability. Of the twelve patients who were so defined the majority of these patients had associated problems of a practical or material nature. For example, a

17 year old woman who was diagnosed as having severe hypertension when she presented for contraceptive advice was referred to a hospital out-patient department. The patient was later found to be a frequent non-attender to the hospital due to the relatively high cost of travel. The attached social worker was called upon to liaise with the hospital social work department in order to arrange travel expenses. In general the social worker was not central to the illness-treatment process of patients with definable physical symptoms although one might predict that there was an extensive "hidden" physical pathology amongst her patients.

Many of the social worker's patients were however diagnosed as suffering from some form of mental ill health. The majority of these patients were said to suffer from depressive illness and anxiety associated with their social environment and social circumstances.

The detection of family and domestic problems and problems of mental health reflects the social worker's experience and professional interests. The attached worker had previously worked as a locum case worker in the local psychiatric hospital. She continued to maintain an interest in child and adult psychiatry, particularly alcoholism and sexual dysfunction when she joined the practice. The results thus reflect her interest in and ability to explore problems of mental ill health and family dynamics, and the impact on her work of working within a medical environment.

There appeared to be little overt disagreement between the participants in their definition of the patient's primary problem. There was, however, one category of patients who were the source of much

disagreement between the participants; children who were defined by the referral agent as physically or emotionally 'at risk'. The social worker was referred eight such cases and defined the problem as a manifestation of wider family relationship difficulties. The social worker found it especially difficult to deal with the judgments of staff which were coloured by their personal values, ethics and morals. This was particularly true of cases in which the social worker held equally firm views of what "ought to be done" for the patient; what the patient "ought to do" and; who were the "most deserving cases" for the scarce material and professional resources that were available. Conflicts in perception between the referring agent and the social worker led to a breakdown in understanding, loss of sympathy and the development of distrust between the participants.

The social worker reported that she did not find any of the referrals "inappropriate". Indeed she reported just the reverse: each new referral brought with it an opportunity to exercise a broad range of skills.

Functional Expectations of the Social Worker's Role

The referral agents were asked to specify the function or functions they expected the social worker to perform. These functions represent a wide range of activities some of which are couched in rather vague terms, e.g. social support and others which are more specific, e.g. liaison with external agencies.

Table 10 (p.218) shows that in 51% of the referrals medical staff expected the social worker to carry out an assessment function. The

assessment function expected of the social worker took two principal forms; problem-oriented assessments and task-oriented assessments. Problem-oriented assessments were those in which the social worker was expected to help investigate, clarify, and interpret the patient's social history, their problems and needs. Such requests were most often associated with cases where the patient presented either vague psychosomatic complaints or the referral agent suspected that there may be hidden undisclosed pathology. Task-oriented assessments were those in which the referral agent, uncertain of the social worker's ability and skill, requested that she assess and define the contribution she could make to the care and treatment of the patient.

Staff in both health centres called upon the social worker to carry out a wide range of practical social service functions, e.g. providing the patient with advice and information about benefits and allowances, arranging aids and adaptations and making provision for additional domiciliary services. In addition medical personnel hoped that the social worker would offer certain patients support and the opportunity to discuss their problems in a friendly and relaxed atmosphere. This was viewed as an extremely important function which only the social worker could offer as and when the need arose.

There were marked differences between the two groups in their functional expectations of the social worker's role in all of the categories. A number of factors account for this. The expectation that the participants had of the social worker's role was shaped by their training, experience and professional interests. For example those GP/psychiatrists with an interest in alcohol related problems referred problem drinkers with the expectation that the social worker would carry

out an assessment, counselling and supportive function. In contrast to this the district nurses tended to refer elderly patients with the expectation that the social worker would provide material aid. Differences in staff composition and the clinical interests of staff thus had an impact on the result. Secondly the variation between the two groups reflected differences in the relative experience of the participants at both an individual and organisational level, of working with social workers. Health Centre A staff had less experience of working directly with a social worker in general practice than their colleagues in Health Centre B. Thirdly, the differences in role expectations between the two groups is attributable to the changes in perception of the social worker's role amongst certain key referral agents. Physicians in Health Centre A who at one time had referred patients with a complex range of problems, which demanded a wide range of social work skills, began to refer straightforward practical problems (e.g. financial problems, requests for holiday placements and domiciliary care). They no longer expected the social worker to engage in more complex activities such as counselling and psychotherapy. Indeed in the most extreme instances certain members of staff stopped referring cases to the social worker entirely. This hardening in attitude towards the social worker was in response to her perceived lack of commitment to the practice (e.g. her failure to attend meetings of the psychiatric team) and her failure to provide follow-up information once a referral had been made.

Functional Expectations and the Social Worker's Reported Role

When we compare the referral agent's expectations of the social

worker's functional role and relate these to her reported activities we find marked differences in the two reports. (Table 10)

Table 10 : The Referral Agent's Expectation of the Social Worker's Function and the Social Worker's Reported Function

Function	Health Centre A				Health Centre B			
	<u>Referral Agent</u>		<u>Social Worker</u>		<u>Referral Agent</u>		<u>Social Worker</u>	
	No.	%	No.	%	No.	%	No.	%
Assessment/ clarification	28	58.3	46	95.8	15	41.7	36	100
Material aid	26	54.2	14	30.4	12	33.3	16	44.4
Practical advice/ information	10	20.8	10	21.7	14	38.9	23	63.9
Discussion, support encouragement	13	27.1	12	26.1	17	41.2	19	52.8
Guidance/ counselling	3	6.3	13	28.3	7	19.4	3	8.3
Supervision/ surveillance	5	10.4	1	2.2	0	0	0	0
Advocacy, mediation, liaison	6	12.5	24	52.2	3	8.3	13	36.1
Referral to outside agent	1	2.1	2	4.3	0	0	1	2.8
No action taken	NA	NA	2	4.3	NA	NA	0	0
Other (including some psychological therapy)	4	8.3	4	8.7	2	5.6	0	0
Total*	96		128		70		111	

*Totals add up to more than 100% because of multiple answers to the question

Major differences occurred in relation to the expected and actual

occasions on which the social worker undertook an assessment function and acted as a negotiator and/or mediator.

In the context of Health Centre A discrepancies between the reports were most marked in relation to the number of occasions in which the social worker; arranged for or provided material or financial aid; undertook guidance and counselling functions and; acted as an agent of social control, i.e. supervisory/surveillance functions. With respect to Health Centre B the participants differed in terms of the number of occasions in which the social worker; provided material aid; gave practical advice and information; and acted as a guidance counsellor.

On a more general level the referral agent and the social worker differed in terms of their perception of where the social worker's skill was most needed. For example staff expected the social worker to 'keep an eye on families in which a child(ren) was thought to be 'at risk' of neglect or injury. Aside from being kept informed of any new developments that occurred within the family the referral agent also hoped that surveillance would bring about changes in the patient's behaviour toward the child. From the point of view of the social worker her principal role in these cases was to educate parents about parenting and to be on hand to provide advice, guidance and support. Not surprisingly she therefore did not provide the referral agent with the up-dated information they wanted. The social worker tended not to refer patients on to other agencies, not least the local social work department once she had carried out an assessment interview. Her lack of enthusiasm for channelling patients to other workers and agencies is attributable to a number of factors: having carried out a preliminary interview with the patient the social worker felt that a working

relationship had been established which she did not wish to break.

The social worker commented:

"I always find it difficult referring cases on that I've already seen. Having made a relationship I don't like to close it or pass it on. I think that's pretty much me, it's the way I see things".

The social worker hesitated from making use of the area team as she found, like her health centre colleagues, that the social work department maintained a somewhat restricted definition of its function: the area team social workers tended to re-refer such cases to other voluntary or statutory services, e.g. CAB. A number of area team social workers were, in addition, of the opinion that such referrals de-skilled their professional practice. The attached worker therefore found it expedient to deal with the case herself.

Knowledge of the Social Worker's Activities

Follow-up interviews with staff during the post-referral period revealed that in slightly more than 40% of the cases staff had received no additional follow-up information about the social worker's activities nor the outcome of her intervention. (Table 11)

Table 11 : The Referral Agent's Knowledge of the Social Worker's Function compared with the Social Worker's Reported Function

Function	Health Centre A				Health Centre B			
	Referral Agent		S.W.		Referral Agent		S.W.	
	No.	%	No.	%	No.	%	No.	%
Assessment clarification	11	(22.9)	46	(95.8)	16	(44.4)	36	(100)
Material aid	11	(22.9)	14	(30.4)	7	(14.6)	16	(44.4)
Practical Advice information	5	(10.4)	10	(21.2)	10	(27.8)	23	(63.9)
Decision/support encouragement	10	(20.8)	12	(26.1)	13	(36.1)	19	(52.8)
Guidance/counselling	2	(4.2)	13	(28.3)	0	(0)	3	(8.3)
Supervision/surveillance	1	(0)	1	(2.2)	0	(0)	0	(0)
Advocacy, mediation liaison	11	(22.9)	24	(52.2)	7	(19.4)	13	(36.1)
Referral to outside agent	2	(4.2)	2	(4.3)	1	(2.8)	1	(2.8)
No action taken	1	(2.1)	2	(4.3)	0	(0)	0	(0)
Don't know	21	(43.8)	NA	-	15	(41.7)	NA	NA
Other	2	(4.2)	4	(8.7)	0	(0)	0	(0)

With the exception of the referrals made by the social worker to outside agencies the participants consistently under-reported the range and number of activities the social worker reported she had undertaken. Certainly selective recall may account for part of the discrepancy between reports: medical staff may have been unable to recall the detail and content of their conversations with the social worker in the post referral period. However, it was clear that the social worker

found it difficult to keep her colleagues informed once a referral had been made. In the allocation of her very scarce time the social worker defined her priorities consistent with her view of her role, in which the feedback of information to her colleagues had a low ranking. Direct work with clients was ranked higher than building a purposeful relationship with her colleagues in the health centre, and, as I shall show in a later chapter, the area team. Further, in the absence of full-time clerical support the social worker also found it difficult to make up-to-date entries into the medical records. An examination of the records revealed that the social worker was an infrequent contributor to the patient's medical record and those entries which were made tended to be of a cursory nature, e.g. 6/8/79 Visited Mr Smith and discussed his drink problem and rent arrears: 28/01/80 Contacted relatives and checked on Part IV accommodation: 10/01/80: Discussion with Mr and Mrs Smith will write to DHSS.

In effect once the patient had been referred to the social worker a new relationship was developed independently of the health care system.

Despite these limitations the majority of the participants expressed satisfaction with the social worker's efforts. (Table 12)

Table 12 : Referral Agents' reported satisfaction with Social Worker's intervention

Assessment	Health Centre A		Health Centre B	
	<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>
Satisfied	33	68.8	26	72.2
Partially Satisfied	3	6.3	0	0
Dissatisfied	12	25.0	8	22

The simple knowledge that the social worker had carried out an initial interview was enough in itself to merit the approval of many of the participants. In a significant minority of referrals medical staff expressed only partial satisfaction and in some cases complete dissatisfaction with the social worker's response. The primary complaint was almost exclusively that of 'lack of feedback' once a referral had been made. Certainly this group made their dissatisfaction known to the worker in both explicit and implicit ways. The social worker felt unable to satisfy their demand for information while at the same time fulfilling her casework function.

Case Study

A number of problems and conflicts in the social--medicine relationship have been identified in this chapter. These conflicts, to do with role conflict, may be best illustrated through an in-depth look at two cases that were referred to the social worker during the enumeration period.

The first case involved the referral of a five month old infant from one of the GP/paediatricians. According to the physician, Dr Deans, the reason he brought the case to the social worker's attention was his concern for the physical safety and well-being of the baby; he feared that the baby was 'at risk' of non-accidental injury at the hands of her parents. During the interview with the doctor, on the day that the referral was made, he explained his reason for referral as follows;

The problems are really on-going. Here we have a girl who at the age of 15 delivered her first baby. She married young, because of the pregnancy, and the father is young (the father was 21). The baby is, or was,

a 'premmie' (born prematurely). Because of the general quality of her development there's a good chance that there will be continuing problems of development and that she'll be susceptible to certain problems because of her low birth weight. And this has happened. There has been limited weight gain and a 'failure to thrive' and for this reason she was admitted to 'Sick Kids' (Royal Hospital for Sick Children).

The problem is that we've got an immature couple struggling with a small baby. The case has all the signs of a potential child at risk. As I said, an immature couple who married young because they had to, and a mother who after a difficult pregnancy gave birth prematurely.

The GP went on to give some additional details of the parents' social history which heightened his concern for the welfare of the infant:

Another reason why I referred the patient to the social worker was that the father has no settled occupation. He has a very poor work record and currently he's unemployed. Why he can't seem to hold down a job I don't know, although I suspect that he has trouble getting out of his bed in the morning. The other thing is that I had the mother up here the other day and she said that she was becoming anxious; that she was finding it increasingly difficult to cope with the baby and that she was frightened that she might 'batter the bairn'. She admits that this is a possibility. So the maternal--child interaction is very poor and a very real problem. It's a classic case where the GP and the medical (sic) social worker have to keep in close contact.

The GP reported that he expected the social worker to; visit the home and check that the basic requirements of the baby, warmth, food and clothing, were being met by the mother and father; talk to the father about his employment prospects and his employment problems; and finally

to keep a 'watching brief' on the family by monitoring and supervising 'the home situation over the next few months'.

The social worker, on the other hand, reported that the reason she had been referred the case was because of straightforward financial problems and because of the baby's recent admission to hospital for 'failure to thrive'. When she visited the home a week after the referral had been made, she reported, to the researcher, that 'Mr Brown has found a job and things seem to have righted themselves'. The social worker then paid two subsequent visits to the family, made contact with the hospital social worker for additional information on the child's state of health and development, and 'arranged a payment scheme for the husband to repay an outstanding debt to the Electricity Board'. The case was at this stage closed by the social worker who informed the parents that should they have any further difficulties they were to call her.

During her short period of involvement with the family, the social worker did not keep the GP informed of her activities, her assessment of the case, and her decision to close the case. During the final follow-up interview with the doctor he reported that he knew little about the social worker's involvement and activities, other than the fact that she had 'visited the family', nor was he aware of the social worker's assessment and findings. While he appreciated the social worker responding to his request to investigate the infant's circumstances, he was 'less than happy with the feed-back'.

This case study shows the private nature of the social worker's consultation with the client. Once a referral had been made to the

social worker she was able to 're-define' the problem, the patient and her role in response to the referral. This behaviour was even more marked in the referral of a 33-year-old divorced ex-builder who had a long clinical history of alcohol abuse. The patient had returned to his home after a short stay in hospital for 'detoxification'. At the time of the referral he was under the care of the GP/Psychiatrist, Dr Elder, and the community psychiatric nurse, Ms Flowers. I was able to observe and record the details of the referral as it was made to the social worker by the GP, who had just finished discussing the case with the psychiatric nurse.

GP: (to the social worker as she walked into the nurses' room)

"I've got a patient for you. I don't know if you can do much for him at this stage and if you don't think you can just say so."

SW: "Oh good. By the way I caught up with Bill McKenzie. ..he starts work on Monday".

GP: "He's got a job?"

SW: "Yep, shift work, factory work at the asbestos factory. I've made an appointment to see him in a fortnight. By that time he should be in good shape".

GP (to the community psychiatric nurse)

"What a social worker eh Claire? Now about this other problem. His name's Jim Clark. He's recently been discharged from (the local psychiatric hospital) where he voluntarily admitted himself for detoxification. He's back at home now and he's joined the local AA. Claire and I are seeing him at the Family Health Clinic (the psychiatric clinic) and Claire's seeing him at home. He's mentioned that he's interested in getting back to work which, you might agree, is a further stage in his recovery and rehabilitation. We were wondering if you could provide him with assistance with regard to the employment situation and reinforce our work with him. You know, make encouraging noises, support what we've been saying to him. Do you go along with that?"

SW (grudgingly): "Yeh, I'll go along with that".

However, when the social worker was interviewed later that day she reported:

"As I see it the reason I've been asked to be involved in this case is because of alcoholism, and for the moment I'm going to stick to that".

Later the social worker reported that her work with the patient was strictly related to counselling; discussing the patient's drinking habits and exploring the reasons for his drinking behaviour. When the discrepancy between the doctor's version of what she was to do and her own version of events was pointed out the social worker justified her clinical focus on the grounds that:

"There is absolutely no point in doing anything about the employment issue or discussing his getting a job until I'm sure that his drinking is under control. At the moment I'm not satisfied that it is. So for the moment the counselling role is the most important thing I can do".

Follow-up interviews with the GP and the psychiatric nurse revealed that they had received no further information from the social worker once the referral had been made. Their knowledge about what was happening within the social worker-patient consultation was restricted to information gleaned from what the patient said about the social work visits, which was no more than 'he'd been by to see her'.

Most of the cases to do with problem drinkers were discussed in the weekly psychiatric team meetings which the social worker chose not to attend on the grounds of 'pressure of work'. In conversation with the social worker she reported that the underlying reason for her lack of attendance was because 'they're a waste of time. All we seem to do is tell each other what we've been doing and what the patient said.

Nothing positive ever really comes out of it'. The failure on the part of the GP to command the social worker's attendance to the weekly conference and her failure to report back once she had seen the patient led him, and others, to attempt alternative strategies of control. This took the form, as I have reported earlier in this chapter, of using a formal letter of referral in the hope that she would respond by supplying a formal record of her involvement in the case. When this tactic was tried and failed, the GP in this case stopped referring cases to the social worker entirely, and directed all of his referrals to either the psychiatric nurse or the health visitor.

The Social Work--Medicine Relationship

These two case studies highlight a number of interesting features to do with the structure of the GP--social work relationship. Once a referral had been made to the social worker a new relationship between the social worker and the patient was formed, independent of the clinical process. Once this independent relationship was established the social worker was in a position to act in an autonomous fashion, free of medical interference and control. This meant that the social worker was able to ignore, re-interpret and modify the original grounds for the referral being made. In this way, the social worker was able to manipulate the case so that her work was made interesting and professionally rewarding. This tactic carried a certain amount of risk in the form of role conflict with the doctor whose perceptions of the problem and reasons for referral differed markedly from her own. It was therefore in the social worker's short term interest to conceal her motives and actions from the gaze of the doctor, and this she effectively accomplished. The privacy of the consultation process acted as a tactical means of resisting or avoiding medical control of the

social work—client relationship and at the same time protected the social worker from direct confrontation with the doctor. The social worker was able to establish jurisdictional boundaries around her work with the patient which acted as jurisdictional restrictions on the doctor's power or 'medical dominance'. Another factor which limited the medical profession's ability to control the social worker is the inherent lack of programmability of her practice, as seen in the ease with which the social worker was able to re-cast her problematic and her role definition. The doctors were unable to prescribe the action the social worker should take in response to their referral. The penalty the social worker paid for this behaviour was the relatively limited influence she had over the doctor. For example she did not occupy a particularly favourable position to persuade the doctors to change or modify their ideas, values and beliefs about the nature of the problems they encountered in general practice, how they viewed the patient and their definitions of the social worker's role.

In addition, these case studies show us something about the limitations in the scope of the doctor's power and influence over the worker. I reported in an earlier chapter that many of the practitioners anticipated that with the attachment of the social worker to the health centre they would be able to monitor, evaluate and control the work and activities of the otherwise independent social worker. That is, they anticipated that the attachment would provide them with the opportunity to exercise their traditional authority over the subordinate worker. Secondly, while the doctors were able to control the number of referrals to the social worker (her work load) they were not in a position to effectively monitor, assess and control the form and content of the

social worker's transactions with the patient. It can, therefore, be argued that at least in relation to the medicine--social work relationship in the health centre, the power of the doctor was not pervasive but related to particular scopes (the sphere of the subordinate's conduct which is controlled by the doctor). Further, when the doctor attempted to extend his power into new scopes e.g. prescribing the social worker's actions in relation to the patient, this generated resistance on the part of the social worker.

Even the doctor's control over referrals was subject to constraint. In the case of the health centres under discussion the social worker was faced with a surfeit of work generated by the doctors and health visitors. In this situation the decision by an individual doctor to call a halt to referrals to the social worker was treated as a welcome respite from new work by the social worker, rather than as a negative sanction. So long as she was not dependent on one or two sources of work the actions of a single doctor had little effect on her behaviour. To be an effective strategy of control, the doctors would have had to have acted collectively, agreeing to call a halt, or threatening to call a halt to all referrals to the social worker.

It appeared from the data that the GP and the social worker alternated the role of power holder and power subject in the course of their interaction. While the doctor may rule the referral of cases to the social worker, once a referral had been made the social worker controlled the social work--client encounter. These and other related matters will be taken up and elaborated upon in the next chapter.

SUMMARY

In this chapter I have examined one aspect of the social worker's total workload within the health centres; her response to formal referrals made by health centre personnel. Excluded from the study were the indirect services she provided to patients in the form of discussions with staff about patients with whom she was not in contact and her activities as a member of the child psychiatric team and the sexual dysfunction clinic.

Approximately 97 patients, and in some cases their families, were referred to the social worker during the enumeration period. The majority of these patients were women; four times as many women than men were referred to the social worker. 68% of the patients fell within the 15 to 44 year old age group and 35% were married/cohabiting. 25% of the patients were either living alone or in small households. The employment of the patients placed the majority of them in Social Classes IV and V, semi-skilled and unskilled manual occupations.

The doctor was the primary source of referrals, referring twice as many patients as the next highest user of the social worker's services, the health visitor. Other members of the primary care team did not figure prominently as a source of new cases. The majority of referrals, 62%, were made verbally in the course of informal face-to-face discussions. However, there were certain practitioners who at first as a matter of routine and later in a bid to influence the social worker's behaviour, resorted to the use of more formal methods of communication.

A large proportion of the patients were diagnosed as having complex

multiple and in some instances long-standing problems. Physical ill health did not play an important part in either the referral agent's decision to refer the patient or the social worker's subsequent assessment of the case. Mental ill health was, on the other hand, identified as an important factor in the referral process.

Different categories of staff tended to refer different types of patient, e.g. the district nurses referred elderly patients experiencing material problems, the health visitors tended to refer families with young children, who were experiencing domestic problems and so on. The incidence of major and minor mental ill health amongst social work patients thus reflected the extensive background, experience and interest of health centre personnel in such problems.

Results from the interviews show that a wide range of complex factors influenced the participants' decision to refer the patient to the social worker. No single factor could be said to account for a referral being made. The one possible exception to this were cases where the patient had asked to 'see the social worker'.

Analysis of the data revealed that factors other than the patient's presenting problem were involved in the medical worker's decision to refer to patient. These factors included; knowledge of the patient's clinical and social history; the agent's subjective judgment of what 'ought' to be done with, or for, the patient in light of certain moral and ethical considerations; the referral agent's interest in managing the case and, the social organisation of the medical practice.

The majority of the social worker's patients were assessed as having practical and environmental problems, family relationship

problems and problems of mental ill health. The patients' problems were, primarily, associated with their age, sex, marital status and social class.

Analysis of the data did not reveal a strong 'clinical' component in the social worker's activities, e.g. checking to see that patients were complying with a treatment plan, or advising patients about contraception. Nevertheless the general spread of problems presented by the patients accorded the social worker the opportunity to employ a wide range of social work skills. The principal functions undertaken by the social worker included; assessment, advocacy, mediation and liaison with outside agencies; social support and the provision of material aid.

The attached worker reported that she did not find the referrals inappropriate nor did she feel that staff "dumped cases in (her) lap". She considered all of the referrals appropriate for social work intervention, but nonetheless, there were marked differences between the participants' reports of the reasons underpinning the referrals. The referral agents unilaterally reported between 33% and 50% more factors which they associated with their decision to refer the patient than the social worker. This discrepancy is explicable by the tendency of the social worker to engage in a reductionist process: the social worker "de-constructed" the complex totality of information she received at the point of referral in order to make sense of the referral and identify a starting point for her intervention with the client.

There were also marked differences between the referring agents and the social worker in terms of the agent's expectations of the social worker's function and their knowledge of the social worker's activities

once a referral had been made. The referral of the patient to the social worker resulted in a new relationship being formed which was independent of the treatment process.

The social worker found it difficult to keep medical staff informed of her findings and her activities. Consequently her contribution to the development of a more comprehensive picture of the patient and their problem was restricted to a few exceptional cases. Her perceived failure to provide certain staff members with follow-up information (feedback) about the case was the source of much latent and overt tension between the participants. Further, the social worker missed the opportunity to use case discussion as a means of educating medical staff about the nature, principles and practice of social work.

In the absence of a clear understanding of the social worker's ability and skill some of the participants found it difficult to differentiate between the role of the social worker and other allied health centre personnel, particularly the health visitor and the community psychiatric nurse. As a result of such ambiguities the patient could, on occasion, find himself or herself being passed, 'bounced', from one staff member to another as each worker assessed the nature of the problem and determined the contribution they could, or could not, make for the resolution or amelioration of the problem.

Despite these limitations the majority of health service staff expressed satisfaction with the social worker's involvement with the patient. The simple fact that they knew that the worker had interviewed the patient and that "something was being done" was enough to merit their approval of the social worker.

CHAPTER SIX

THE SOCIAL WORKER IN THE HEALTH CENTRE

This chapter is concerned with the social worker's experience of working in the health centre setting during her first year of practice. It includes a description of the worker's typical day and her relationship with the health centre participants. It also examines the strategies that she and the doctors employed to gain control over her work and to cope with conflict.

The First Six Months

The attachment began with the majority of the participants expressing satisfaction at having achieved their ambition of gaining 'their own social worker'. When the social worker joined the groups she received a warm and friendly welcome from all of the participants, even those who, like some of the health visitors and the clinical psychologist, were somewhat cautious of having a social worker as a member of the team. The social worker was taken around the centres by the Health Centre Administrators and personally introduced to her new colleagues. Later she was to receive an official welcome to the settings at the health centre management meetings. In response the social worker informed her new co-workers that she looked forward to developing the post and contributing to the work of the primary care team. Privately, she stated that she thought the placement held out the prospect of making a valuable and rewarding contribution to her career .. 'it won't do my career any harm being here. I'll be able to do work that a basic grade worker in area team couldn't hope to handle'.

The social worker's first two to three months in the centres was a period which the participants used to get acquainted with each other. The newcomer in particular was faced with a bewildering array of details about the organisation of the two centres, and the area team, which she had to learn. This was an interesting time for the worker who 'picked things up and put things down', as she 'sampled' the wide range of groups, events and meetings that took place within the centres. During this period she was a regular and interested observer-participant to management meetings, practice meetings and clinical meetings held in the centres. Concomitantly, the health centre participants took every opportunity to meet their new colleague and engage her in congenial conversation over a cup of coffee in the staff lounge and the nurses' room. These various formal and informal encounters provided the social worker with the opportunity to 'sus out' and learn something about those with whom she would work, what they expected of her, how the meetings were organised, who attended and what was discussed. On the basis of her preliminary observations she assessed the value and importance of each event to the development of her post and her own special interests. She then made decisions about where she would invest her time and her energy. In effect the social worker 'cased' her working environment to see how and where she could fit in.

The Social Worker's Day

Fieldnotes recorded at the time show that the social worker's working day looked something like this:

On Monday the social worker arrives in Health Centre A at 8.45 am to attend the weekend 'debriefing session'. These meetings allowed

those who had been 'on call' during the weekend to provide a report to their colleagues about the patients they had seen and the problems they had encountered. Following the meeting some of the participants, those who did not have an early surgery or clinic, had the time to 'tackle' one another in order to discuss a particular case, e.g. 'Is there any chance that you could pop in to old Mrs Gray? She was at the clinic on Friday and I'm a bit worried about her chest'; and exchange information on matters of common interest, e.g. 'The Health Board is sending us an Australian GP who's on study leave. I thought I'd arrange to meet him for lunch before I show him around the centre. You interested?' The participants also used the time between the end of the meeting and the start of their working day to get to know a bit more about the social worker, her background and interests and become generally more familiar with her.

The rest of the social worker's morning was usually spent dealing with correspondence, arranging appointments for the week, telephoning agencies to find out information about an active case or to act on behalf of her patient, writing up the case notes of the patients she had seen on a previous day, and seeing patients either in their homes or in the health centre. (1) Between visits she might call into the coffee lounge or the nurses' room for an informal chat with the nurses or a GP. These informal encounters were also used by the different parties to exchange notes about the background or the condition of patients she had just seen. Such meetings tended to be brief and to the point, highlighting the pervasive sense of urgency in Health Centre A which surrounded much of their work, a sense of people working under the pressure of not having enough time and resources to deal with all that

had to be done.

On Friday morning the social worker might be found attending one of two meetings; in Health Centre A attending the meeting of the psychiatric team, or in the social work department attending the area team meeting. Present at the psychiatric team meetings were the GP/Psychiatrist, Dr Elder, the community psychiatric nurse, Sister Flower, and, on occasion, the community psychologist and the consultant psychiatrist from the local hospital. These meetings served a number of functions: to exchange information about patients being seen by the parties; to report on the patient's progress or his lack of progress; to exchange ideas about diagnosis and prognosis, which often developed into spirited debates over the definition of the patient's problem and the best means of helping him; to transfer active cases from one party to another; and, to refer new cases to the individual who volunteered to act as the patient's 'key worker'. As this meeting clashed with the area team meeting the social worker was faced with a choice of where she would invest her time. During her first six months of practice the social worker attended the psychiatric team meeting on approximately six occasions and the area team meetings on three or four occasions. As time progressed the social worker became an infrequent visitor to both meetings and finally she attended the psychiatric team not at all.

Initially the social worker would return to either the health centres or the social work department for lunch. The lunch breaks were a particularly active time of the day in Health Centre A where the participants had established routine Wednesday practice and clinical meetings. The former meetings, 'the practice meetings', took the form

of a member of the practice team or an invited speaker giving a presentation on a matter of general interest. Topics that were discussed included; new health education programmes in the United States for hypertensive patients; prescribing policy for alcohol abusers at the local psychiatric hospital; the task and function of Marriage Guidance; and the role of the health visitor in primary medical care. The latter meeting, the clinical meetings, were especially interesting insofar as members of the health centre, notably the GPs, presented a 'post mortem' of cases which they had mis-diagnosed. The individual in the spotlight explained what it was about the case that had led him to make a particular diagnosis, where they had 'gone wrong' and what they had done in response to their error of judgment. Alternatively, these meetings could take the form of the participant presenting the details of an active case which was causing him a great deal of difficulty. The meeting was then thrown open for the participants to ask questions and offer alternative diagnosis of the patient's complaint and alternative treatment strategies. On some occasions the meeting ended with a member of staff offering to see the patient to 'see what they could do'. The organisation of these meetings was taken up on a rota basis by any member of the health centre who cared to volunteer. It was a generally held expectation that the efforts of the organiser were to be rewarded by all of the health centre staff, with the exception of the receptionists and clerical workers who were not invited to attend, making an attempt to attend and occasionally preparing a paper for their assembled colleagues. (2)

The social worker attended two or three of these gatherings when she first arrived. She then stopped attending altogether. At the start

of the attachment she had arranged to spend the entire Wednesday, the day of the practice/clinical meeting in Health Centre A, in Health Centre B. As a result, she decided not to return to Centre A 'in case I get caught up in things there'.

The social worker decided to make herself available in Health Centre B for informal discussions with staff over lunch. As time went on, however, she again adopted a 'low profile', avoiding the more public arenas of the health centre for fear of bumping into colleagues who might request her involvement 'in yet another case'. In addition she began to use this 'free' time to catch up on the work that had accumulated that morning or from the previous day.

The social worker would spend the afternoon in the Health Centre B seeing patients or visiting them in their homes. Late in the afternoon she would return to drop off her files and cover any outstanding business.

During her first six months of practice the social worker faced the not inconsiderable inconvenience of being inadequately furnished with office equipment, e.g. filing cabinets. The social worker plied between the centres, the social work department, the hospital and the homes of the patients with her records and other documents. Later she was able to beg and borrow equipment from the centres and the area team as an interim measure. It was not until her eighth month in post that the health board provided the worker with her own office equipment.

The practical and material problems described above reveal a more fundamental issue - the conflict between the needs of the attached social worker and the organisational policies and principles of the

employing authority. In the document Social Work Services in the Scottish Health Services(SED, 1976) the authors place the responsibility for servicing the needs of the attached worker in the hands of the Health Board:

The health board should ensure that administrative and clerical support accommodation and other services provided (for) social work staff in hospitals and health centres is fully adequate.

The executive officers of the social work department maintained that the Health Board was responsible for meeting the needs of their attached worker. The worker was therefore actively discouraged from making alternative arrangements e.g. arranging additional secretarial support from the local department, accepting equipment from the centres, for fear of setting a precedent for future attachments. At the same time the health board was under pressure from central government to control their spending. The attached worker found herself trapped between the principles of her employing authority, the resistance of the Health Board to accede to those principles and the daily demands of her work. Given these opposing interests positional conflict was almost inevitable. This issue will be taken up and expanded upon in the following chapter.

Within a matter of two months, the social worker's working day began to extend into the evening. She was of the opinion that the only way to deal with the expanding mountain of unfinished work was to do ever increasing amounts of overtime. In addition she became involved in a number of other activities, such as attending meetings, in the hospital, of the Sexual Dysfunction Clinic because she acted as the co-

therapist of one of the health centre GPs, Dr Kelly. In addition she represented the social work department, on the advice of Dr Watson, at the local branch of the Council for Physical Handicap. Ultimately she was to suffer what Handy (1976) has defined as role overload, not too much work but too many hats.

Prior to her arrival in the centres the social worker worried about the amount of time it might take to become acquainted with her new colleagues and gain their confidence so that they made 'appropriate' referrals. In fact her initial fears proved unfounded; once she had expressed her interest in 'getting down to work' the participants were only too willing to oblige and began making referrals of the kind of patient and problem that the social worker had expressed an interest in seeing. Within a matter of weeks she expressed surprise at the rate of referral from the participants, and she is recorded as stating 'It's as if they've (the GPs) been storing up patients waiting for someone like me to arrive'. The social worker seemed genuinely unaware of just how accurate her statement was nor was she aware that the behaviour of the GPs at the start of the programme presaged a good deal of trouble for her in the future.

The behaviour of the doctors represented something more than an instrumental interest in getting social work services to their patients. The referrals were also used as a means of assessing what Resnick and Patti (1980) have called the social workers' 'professional credibility'. That is, the practitioners hoped to use the occasion as a means of gauging her professional competence in work with and for their patients.

The social worker found at a relatively early stage in the attachment that the participants held certain normative expectations

regarding her role in the health centre. They treated as 'given' certain prescribed functions which they expected her to perform. For example, in Health Centre A it was assumed by all of the participants that the social worker would take over the role of chairwoman of the monthly health centre--social work meetings from the community psychologist, a role she was happy to divest herself of and willingly give to the social worker. Concomitantly, the social worker was expected to establish and chair similar meetings in Health Centre B. She was slightly annoyed that such expectations were treated as non-negotiable by the participants, that they treated this as 'taken for granted'.

The social worker also found herself acting as an apologist for the perceived failings and limitations of local authority social workers:

"I've had to cope with the primary care, health care team's feelings toward the area team. I've had to deal with their negative feelings about social work and the area team. I find myself apologising for things I had nothing to do with. It becomes a bit of a strain".

The, at times, hostile attitude of the participants toward area team staff was, on occasion, translated into action: the attached social worker was used in cases where the participants declared dissatisfaction with the response of the social work department to the referral:(3)

"They have no faith in the social work team so they filter them through to me - like patients who are referred to the team and then returned without being allocated. The doctors say to me 'I think it's important that they (the patient) is seen by a social worker'. That means the ball is back in my court. Also if they (area team social workers)

don't pick them up quick enough the patient is referred on to me".

In a small number of cases the attached worker discovered that she had become involved with patients already allocated to local authority staff.

In addition she had her first experience of dealing with the clash in occupational cultures when social work and medicine meet. The social worker consistently reported during her first few months in post that she came under considerable pressure to adopt a more directive approach to the patients.

Ms Bishop: "I'm very aware that the medical staff are more directive with patients and they'd like me to be more directive. In some cases it's practical, spelling out the alternatives the person, the patient, has. But still the patient must make the choice. They have to make a decision about what they're going to do. I just spell out the alternatives they might not have thought of. Even if people ask me what they should do or what I think I'm still not in a position to tell them what to do even if there are legal risks".

From her point of view taking a more directive approach with the patient was inimical to the practice of 'good social work' with its emphasis upon client self-determination. Thus during the initial stages of the attachment programme the worker found herself in conflict with certain members of the primary care team over the governing principles and values underpinning her practice. However, this notion of the patients' absolute right to self-determination underwent considerable modification during the latter stages of the attachment. Later the worker commented:

"Of course I choose what alternatives I want to

bring up, to bring to their attention. So I guess you would say that I have a certain degree of control. And yes there are some situations where I might tell the patient "We're going to do this". Especially in cases involving children who are at risk. But it doesn't happen very often".

The professional value system of the worker, rather than being inviolate, was subject to modification and change in light of her experience. The newcomer both to the field of social work practice and to medical practice, recognised, as the differential distribution of power within the social work—client relationship became more apparent, that some limitation of the patient's right to self-determination was inevitable. As Satyamurti (1981), has argued, the social worker's practice is not one that is based on a partnership between equals but one which is characterised by a parent-child relationship. In this case, as a result of changes in the social worker's value system there was a decline in the conflict between the participants over their relative professional values; the directive--non-directive dichotomy. In its place conflicts began to occur as the participants disagreed about the cases in which the idea of patient self-determination was to be upheld or modified. In general then, as one conflict was reduced its resolution was accompanied by, and revealed, another subject of dispute.

The First Year

By her sixth month in practice the attached worker complained that she felt under constant pressure from a demanding clientele and demanding health centre and area team colleagues. The social worker experienced what has been emotively defined in the social work literature as 'bombardment'; a situation where the demand for her services outstripped her capacity to respond to the demands (Davies,

1981; Roberts et al, 1976; Reinach, 1982).

From the point of view of the worker the structure of the post posed almost insurmountable barriers against her integrating with and becoming an established member of the primary care and social work teams. The extent to which she could become involved in any aspect of one setting was constrained by the amount of time she had available to spend there. Both the health centres and the local social work department 'competed' for her as a scarce resource. The social worker found it an impossible task meeting their expectations, and, in her view, the structure of the post made it almost impossible for her to develop a positive sense of "identification" with any one setting. Some of the comments made by the social worker suggest that in her view she had achieved neither the 'right' frequency nor 'right' quality of contact which she deemed necessary for functional integration. In effect the structure of the scheme undermined her efforts to become a known and trusted colleague of the participants.

The tasks and activities undertaken by the social worker developed in a cumulative fashion. Having either undertaken a particular task or responded to a certain type of problem medical personnel tended to treat the episode as though a pattern had been set. Such occurrences then acted as a guide-line to the participants in their future contacts with the social worker. The social worker observed:

"Having started working on strictly financial referrals and requests for Part IV accommodation I can hardly say 'no', I don't want to do that any more'. I don't really feel that I can do that. Whereas if I had stated right at the beginning that I was going to refer these cases up there (the area team) it would now be automatic".

While she was actively encouraged to pursue her own interests and enlarge her repertoire of activities the worker felt unable to do so at the expense of what was to her routine work. The social worker acquiesced to the demands for her services by health centre staff, in an attempt to enhance her usefulness as a resource in an attempt to establish a basis from which to influence her colleagues.

Although it was agreed that the worker was to spend one third of her time in Centre A and two thirds of her time in Centre B, this crude administrative arrangement for 'dividing' the worker's time failed when put into practice. The social worker was surprised to discover that medical staff, particularly the physicians, would break the time rule when faced with unexpected problems which in their opinion demanded the social worker's attention. It was not uncommon for the worker to find herself 'pursued' from one centre to the other by the physicians. She formed the opinion that rather than treating her as a part-time member of staff both groups treated her as "their full-time worker". As I mentioned earlier, in an attempt to come to terms with her burgeoning workload, she resorted to the use of overtime. During the first two months of practice the social worker completed 30 hours of overtime; in the last two months of the year she worked 96 hours.

Unlike her social work department counterparts the attached worker operated in a setting where she was subject to informal, unplanned contacts with patients and professional colleagues. The physical plan of the centres offered the social worker little 'protection' from the spontaneous demands for her time and attention. Nor was the social worker equipped with an administrative apparatus with which to control the flow of work - she lacked 'front-line' reception staff who were

prepared to act as 'gate-keepers', a priority list and an allocation procedure. The social worker was frequently observed being 'button-holed', that is accosted by patients waiting to see the nurse, the physician, or the health visitor, for a 'wee chat'. Medical personnel also took the opportunity to engage the worker in ad hoc discussion as the occasion arose. Indeed the opportunity to make informal contact with the worker was, from the point of view of most of the health service workers, a key advantage of attachment. Unfortunately such encounters, which could take from 5 to 35 minutes of the social worker's time, were not always welcomed by the social worker when she was about to leave the premises to attend another meeting, see clients and the like.

Another problem confronting the social worker was the absolute size of client population she was expected to serve. One estimate of an acceptable ratio has been provided by Strathclyde Social Work Department (1981) who recommend a ratio of one social worker per 10,000 GP patients. Because of the structure of the post the attached worker faced the prospect of providing a service to a patient population twice the size recommended in the report, or approximately 20,000 patients.

As a result of these pressures the social worker experienced another form of role conflict identified by Burchard (1954), conflict that stemmed from the social worker's perception of incompatibility between her work and domestic roles; her work role began to intrude on her private life. Both the social worker and her husband reported that the job had an unfavourable effect on their domestic life. As the social worker resorted to overtime in order to keep up with her burgeoning caseload, she arrived home exhausted from the demands and

stresses of her job and she found it difficult to shake off the worries and stresses that had built up during the working day. After six months the social worker admitted, privately, that she was seriously considering 'packing it all in' and 'taking up a straight social work job in a local authority department. It can't be any more difficult than what I'm doing here!'

In practice the social worker operated in a relatively autonomous fashion, beyond the control of the doctors and her senior social worker. By the end of the year the social worker attended meetings in the centres and the area team rarely and she could be observed slipping unobtrusively from the centres in order to avoid the unwanted attention of patients and professional colleagues alike. Many of the participants became suspicious of the social worker's frequent absence from the health centre and they began to question her 'commitment' to the centre and her colleagues. During the later stages of the study it was not uncommon for the researcher to be approached and pointedly asked; 'Have you seen Jane today? Do you know if she's coming in? How's she getting on? I don't think I've seen her for weeks. How's she getting on in the other centre? Does she like it there?' The participants were not immune from expressing the occasional mild rebuke to the social worker for 'not being around when she's most needed'.

The social worker was also aware that the non-verbal emotional tone of the communications with her colleagues indicated that many of them were far from happy with her behaviour and that in a few cases her relationship with them lacked trust. This simply added to the social worker's sense of tension and frustration with the post and was experienced as another form of role conflict; conflict that arose from

different significant actors, individuals and groups, holding incompatible expectations about her role.

At the end of her first year in practice the social worker's relationship with her health centre colleagues took one of two basic forms; with some she had a close personal relationship. That is her interaction was based on a personal liking for the other, where they shared stories, secrets, beliefs and practices. This relationship was restricted to a minority of the doctors and two or three health visitors. With others she had a formal relationship whereby the interaction was that which was necessary for work. This interaction was no more than talking together, sharing information and informing staff about developments that were taking place.

The fact that the social worker actually stuck it out in the centres despite the pressure that was placed upon her demonstrated her idealism and commitment to the programme, a commitment which some of the participants were either unaware of or unwilling to recognise.

Ultimately the pressure and strain of working in this arrangement proved too great for the social worker to bear and she withdrew her services, on the advice of her senior social worker, from Health Centre A in order to take up a full-time post in Health Centre B. As at the start of the attachment programme, the health centre participants who had 'won' were delighted at the fact that they now had 'their own worker' based full-time in the health centre. The participants in Health Centre A, on the other hand, expressed anger at the fact that there had been no discussion of the proposal; it had been a unilateral decision taken by the social worker, her senior and the area team

leader. They were also annoyed that the 'news' had been 'sprung' on them, not by the social worker, but by one of the Health Centre B GPs, Dr Nelson, who had inadvertently revealed the information at a local meeting of the district's medical practitioners. The social worker had little contact with her erstwhile colleagues once she moved and the contact which did take place was strained and fraught with tension.

GP Strategies of Control; Authority by Inducement

In Chapter One I noted that the GPs viewed the attachment of the social worker to the health centre as a means of extending their authority and control over an otherwise independent occupational group. I also argued in the discussion of the power relationship between the doctors and para-medical and lay staff that they achieved a degree of control over the activities and behaviour of others by offering certain inducements, or rewards, to the subordinate workers in the form of 'interesting' referrals. That is they used positive sanctions to bring about obedience to their commands. It was, therefore, not surprising that once the social worker had identified her interests, which included working with alcohol abusers, patients suffering from marital relationship difficulties and problems to do with mental ill health, the doctors were prepared to respond positively to the social worker's request. That is they provided the promised rewards in the expectation that they would act as inducements to the social worker to behave in the manner they desired.

The offering of inducements, or rewards for compliance with the wishes of the doctor, was of vital importance to the participants at the start of the attachment as a means of influencing the social worker's

attitude and behaviour toward the health centres and the area team. All three groups regarded each other as rivals and competitors for the social worker's time, attention and commitment. Each group therefore jockeyed with the other for a prominent position in the social worker's timetable.

Inducements in the form of 'interesting' and 'appropriate' referrals were used to win the 'heart and mind' of the social worker. In addition, the offering of rewards was viewed as a means of drawing the social worker into the routines and rituals of the centre. Thus the GP/Psychiatrists referred problem drinkers and 'anorexics' to the social worker on the understanding that she would attend the psychiatric team meetings held in both of the centres.

In addition, as I have already indicated in an earlier chapter, the referral of 'interesting cases' was made on the understanding that the social worker would respond to referrals of a more mundane nature, e.g. arranging special payments, dealing with the Electricity Board on behalf of the patient and, when appropriate, take up patients labelled as 'demanding patients' in order to give her colleagues a break. Within the context of the two health centres under discussion the referral of 'interesting cases' to the social worker can be viewed as the 'currency' of 'bargaining chips' which were used as the basis for negotiation.

However, the compliance of the social worker could not be ensured when based solely on her expectation of benefits being conferred by the doctor. The doctors ran the risk that the social worker might not see the inducements as essential and that she might willingly forgo the rewards if she perceived her own interests to be compromised or

threatened by compliance. For example, as I have indicated earlier in the chapter, the social worker reached a stage in the attachment where the referral of patients to other workers would have been welcomed, rather than seen as a negative sanction. For this reason it was to the advantage of the doctor that he extend and diversify the forms of power he exercised over the para-medical and lay workers. The practitioners used a variety of other tactics and strategies to gain influence and power over the worker which were based on what I define collectively as a 'Tavistock' approach to the occupational control; tactics based upon the formation of a personal relationship with the social worker. Many of the practitioners attempted to engage the worker, to a greater or lesser extent, at an intense personal level and then use the relationship as a lever in order to extract agreements and consensus from her.

In order to use their relationship with the social worker, both formal and informal, the practitioners first had to get the social worker into relationship and having done so, maintain their contact with her.

Inclusion

The term inclusion is here defined as a strategy of enhancing and extending the authority of one group by entangling the significant other in a system of rights, duties and obligations from which the actor finds it difficult to extricate himself.⁽⁴⁾ The doctors and the para-medical workers were for two reasons particularly interested in the social worker becoming an active participant in the various groups and events taking place within the medical setting. Given her expressed interest

in problems of human relationships, alcohol abuse, and mental illness the GP/Psychiatrists were in addition emphatic that the social worker attend the weekly psychiatric team meetings. After observing one such meeting the GP was asked to explain why he thought the attendance of the social worker was important. He replied:

Dr Kelly:

"The weekly team meetings are an important part of the services that we provide. At least I think they're very important ... Firstly, it allows all of the team members to keep in touch with what is going on within the 'family unit' if you like. Also if someone is having a bit of trouble with the patient then it's possible for someone else to step in to see what they can do. Sometimes it's a matter of the personalities involved whether or not you have any success with the patient. And you must remember some of our patients are very manipulative. These meetings allow us to come together and exchange notes about what the patient is saying ... Um, from my point of view you can become quite isolated working in general practice, even in a place like this. I mean that there may be developments in psychiatry that I am not aware of or only dimly aware of. I've found that these meetings help me keep up to date with what is happening in psychiatry outside of my narrow clinical field. I've been quite surprised what I've learned. That's why I think it would be interesting to have the social worker join us ... Well as I see it if the other members of the team are making an effort to come to the meetings then we all should make an effort. If someone isn't prepared to make that kind of commitment, or doesn't make the effort then it is unlikely that the team will make the kind of referrals the other person would like to treat ... It really is as simple as that".

Direct observation of the meetings and informal interviews with staff suggested that aside from their instrumental value, helping to co-ordinate patient care and helping to ensure a modicum of continuity of care when two or more parties were involved, the meetings expedited the growth of shared beliefs and shared meanings. It was clear from the comments that they made that they agreed on common definitions to the

situation, including a common definition of the role of the team member or prospective team member. Six weeks after the social worker had joined the practice she attended her first meeting of the Health Centre B psychiatric team. Those in attendance included; the two GP/Psychiatrists, (Drs Hall and Kelly), the community psychiatric nurse (Mr Miller) who chaired the meeting on this occasion, a psychologist from the local psychiatric hospital, a representative from the Marriage Counselling Service, and the attached social worker. This was the only occasion that the social worker attended the group and her absence from the following meetings was noted and commented upon informally by the participants over the following weeks.

Mr Miller: "It's a shame that the social worker hasn't been able to attend, even occasionally. I think it would be good for her and good for the team if she did come along (this to the researcher). Does she attend the team meetings at (the other health centre)?"

These sub-units also formed part of the health centre's political system; they fulfilled a political role in the sense that the participation of subordinate staff was to do both with pragmatic issues and political issues to do with a wider distribution of power within the organisation. It was clear that the parties to the meeting helped to foster and maintain, by their actions, the distribution of power within the health centre and the organisation's way of handling things. The encounter between the community psychiatric nurse, Mr Miller, and the social worker, illustrates this point.

CPN: "...Ah, are you going to be back in time for the (psychiatric) team meeting?"

SW: "I'm not really sure, it's hard to say. It really depends on how I get on (with the patient). I

really can't say positively 'yes, I'll be there'. I can't very well stop in the middle of the session and leave".

CPN:

"Yeh ... Only I really do think that you'd find these meetings pretty valuable to your work here. Also it gives us a chance to get together and talk about the patients and how we're getting on. It's the only chance we have of getting everyone together in one place. Also it's a good pick-up point for the kind of work you're interested in. And Geoff (GP/Psychiatrist) appreciates it when we all turn up".

Such normative appeals and appeals to self interest, and the implied risk of negative sanctions being applied, had little impact on the social worker's behaviour.

From the point of view of the social worker, the nature of her work with clients was such that she could give no certainty of conduct with regard to the health centre meetings. Her decision to decline the 'invitation' to attend was met with some disapproval by the parties who made up the sub-units. Some of the participants defined the social worker's action as a sign of her lack of commitment to the centre and these who practised within. What is interesting here is that the GPs were, in the main, unsuccessful at gaining and maintaining contact control over the worker. That is, getting and keeping the social worker in relationship proved problematical for the practitioners.

Persuasion and Personal Authority

Individuals vary in their reputations for judgment, brightness and ability. Bucher (1970), examining power in medical schools has noted that differences in reputation and stature within the organisation may have an impact on the political process:

The major consequence of assessed stature is that it affects a person's ability to negotiate and persuade successfully, and it is primarily through negotiation and persuasion that the decisions that carry forward the work of the organisation are made. (p.30)

Observing the practitioners in action and from the comments made by various para-medical and layworkers, it was apparent that many of the GPs were highly skilled at forging informal relationships and that they had mastered the use of charm and confidence in relations with subordinate staff. For example, after observing Dr Able cajole his secretary into preparing a paper that he was to give to post-graduate medical students later that week, the health centre administrator commented appreciatively;

"See that Dr Able, he could charm the legs off of a donkey. The girls would do anything for him. Seriously. He really knows how to make them feel good about themselves and he's always so charming. He knows how to get the best out of his staff ... a few of the others that I could name could learn a lot about man management from him".

In addition, many of the practitioners were obviously skilled at persuasion, the ability of a power holder to convince the subordinate or power subject to accept their communication as the basis for their behaviour.

The social worker appeared to be particularly vulnerable to this type of power play. As a newcomer to the centres, unfamiliar with the rules, regulations and the norms of interaction, and with a commitment to making the attachment a success, she frequently acceded to the demands and requests made by the doctors even though by acceding to their request she acted against her own interests. For example, some

months after she had been in post and not long after she had expressed concern about her expanding caseload the social worker was persuaded to take up a referral which ideally should have gone to the local area team. When this general pattern of behaviour was pointed out to her she replied, with a tone of resignation:

"Yeh, I know. But the doctors are awful persuasive. They say things like 'I really do think that you're the best person to be involved in this case'. 'It's awful difficult to say 'no' and if you do it makes you feel as though you've ... I don't know".

Watching their behaviour over time it was interesting to note that when individual practitioners successfully persuaded the other members of staff to enter into agreements and to carry out certain functions it became increasingly difficult for the subordinate worker to refuse the appeals made by doctors in future encounters. In other words in some cases the power of the doctor to persuade the para-medical and lay worker to accept his communication was transformed into personal authority.

It can be argued that a relationship based upon one of the parties using appeal, argument and exhortation to persuade the other actor is not a form of power at all. The potential exists that there will be some give and take in normal relations and that each party will exert an influence on the other. In some cases, during the course of a single interaction the parties might alternate between the roles of persuader and persuaded. However, observing the events and exchanges between actors over time, it was apparent that the persuasive power and personal authority of the GP'S 'measured' by their success in achieving the intended effects, and the outcomes they preferred, was greater than that

of the lower level participants. Yet the doctors differed in terms of their persuasive skills - some of the practitioners were more articulate than others, some were better public speakers than others and some were more intellectually gifted than others. In short, persuasion and personal authority was unequally distributed amongst the participants and as such could be utilised, and was utilised, to win contests in the medical arena.

There was, in addition, evidence which suggested that as time progressed and the social worker became more familiar with the participants and her surroundings that the success of some of the participants to persuade the social worker to adjust her attitudes, beliefs and behaviour declined. The social worker began to resist the doctors' definition of her work situation and their definition of the patient. It was not clear why the power relationship changed in this way. These data suggest that either the doctor attempted to extend his control into areas or situations which the social worker did not think were his legitimate concern, or alternatively the social worker may have become aware of her own interests and when these were compromised by the doctors' appeal, she resisted.

Coercive Power

When the practitioner failed to obtain the preferred behaviour of the social worker, some of them sought to up the stakes and introduce coercive forms of authority. For example, in Health Centre A, late in the attachment programme, a number of doctors requested that the social worker supply them with a formal written response to their formal letter of referral. This measure was introduced in an attempt to 'encourage' the worker to act quickly in response to their referral and as a means

of gaining more detailed information about the social worker's practice. Later practitioners in both health centres became highly selective in the type of problems they referred to the social worker, resorting to professional stereotypes which emphasised the social worker's instrumental role as the 'fixer' of concrete practical problems. As I have shown in an earlier chapter, one GP sanctioned the social worker by refusing to refer patients to her at all.

By the time such measures were introduced into the relationship the social worker was able to rely upon other sources of work and as she was generally able to find something of professional interest in most of the referrals she received, these forms of coercive power had little impact on the social worker's behaviour. In order for such strategies of control and power to be successful one of two conditions had to be satisfied: either the practitioners would have had to have acted collectively and thereby threaten the social worker's total caseload or a significant part of it or she would have to have been dependent upon a relatively narrow source of referrals who then threatened to channel interesting cases elsewhere.

Other coercive measures that were enacted included a formal letter of complaint being sent by one of the doctors, again Dr Elder, to the area team leader and the Health Board criticising the social worker's performance on the grounds that she had not responded to a referral and had not kept the doctor informed of her progress with patients. This complaint did little more than label the doctor as 'difficult' and 'a problem doctor' amongst the social work and health board hierarchy.

Finally, near the end of her first year of practice the social worker began to experience difficulty attracting a significant minority

of the participants to the social work--health centre meetings. The doctors began to use compliance with the social worker's wishes as a bargaining counter to trade for her participation in the other medically controlled health centre events.

The Strategies of Control of the Attached Social Worker

When the social worker first joined the health centres she tended to bow to medical authority by acquiescing to many of the commands made by the GPs e.g. she agreed to deal with patients presenting with problems of a purely practical nature which would not normally be allocated in the local social work department, she agreed to organise and chair the monthly health centre--social work meetings, she took up roles outside of the health centre which the GPs thought would add to her utility and value; such as acting as a doctor's co-therapist in the hospital based Sexual Dysfunction Clinic, and participating with Dr Nelson as a member of the local Council for Physical Handicap. Such behaviour, argues Huntington (1981) represent attempts by general practice based social workers to justify their positions within the setting and to make themselves 'indispensable' to the GP and the organisation of general practice.

The social worker saw conformity as an effective means of achieving the goal of gaining the acceptance of the primary care team. The willingness of the worker to comply with their wishes, and the perceived resistance of social work personnel to fulfil their expectations, produced a situation in which the participants regarded the attached worker, or 'their social worker' as 'all right' but 'the area team is terrible'. The fundamental role of the social worker in the complex configuration of the primary care team was that of the "good social

worker".

As the attachment progressed the social worker became increasingly aware of her own interests and how these conflicted with the interests of the medical practitioners. In order to cope with her situation the social worker devised and implemented individual and often improvised strategies to widen and consolidate her area of control over her working arrangements.

Socialisation

There exists a cultural gap in the attitudes, values, beliefs and principles of social workers and medical personnel. With regard to the present discussion the latter appreciated a model of service based upon the patient making direct contact with the social worker; a directive approach to patient care; a patient centred service and, a rapid problem-solving response on behalf of the worker. The former appreciated a model of service delivery based on referrals from professional staff; a non-directive approach to patient care; and a process of intervention which accepted long term involvement with the client which often did not result in the resolution of their problem. The social worker adopted a number of techniques which were designed to bridge the cultural gap and achieve a basis from which to develop her working relationship with the other participants: she attempted to socialise her colleagues into tolerable forms of behaviour by prescribing certain forms of behaviour and proscribing others. For example, at the outset of the attachment, the social worker established a rule that all patients should be seen by a member of medical staff who would then refer the patient to the worker. The fact that the general practitioners were in favour of patient making direct contact with the

social worker whereas the social worker insisted that the patients first see a medical worker is perhaps surprising. One might have expected the reverse; that general practitioners would want to control the referrals to the social worker and that the social worker would want to be independent from medical control. The social worker's demand meant that she relinquished some control over her work and made herself dependent on medical practitioners. She took this decision at the urging of her superiors. This is in keeping with her and her superiors' apparent lack of awareness of the implications of some of the basic decisions that were made. At a later stage in the process the worker called for a complete moratorium on referrals and the like. However, such attempts at socialisation often fell short of achieving their aim. The relative power of the doctors to define the work situation meant that the social worker's attempts to programme their behaviour were thwarted.

When the interests and ideas of the doctor were in some way compromised by the prescriptions for behaviour laid down by the social worker the GPs collectively ignored the social worker's rule and continued to behave in a manner geared to their interests. What is of equal interest here is the response of the social worker: rather than challenging the doctors and squarely facing the conflict in ideas, perspectives and interests the social worker tended to sacrifice her own interests by responding to their demands. For this reason the worker turned to other means of control.

Negotiation

A number of researchers have drawn attention to the conflict which occurs between social workers and health visitors in primary medical care. Role ambiguity, role overlap, competition for patients and a common interest in certain types of problem are key factors used to explain the problematical relationships between the two groups (Corney, 1980b, 1983; Dingwall, 1983; Hicks, 1976). Unlike previous studies of attachment the social worker reported that she encountered few problems working with the health visitors:

"There are cases where both the health visitors and myself have been involved, are still involved. It's an asset being able to discuss cases and have contact with the health visitors. We can decide what we're going to do and certainly it's helped them in cases of 'query' child at risk. Also these discussions have helped me explain my position to them".

This positive view of her inter-occupational relationships did not however extend to all members of the primary care team; the social worker singled out her relationship with the district nurses as especially problematic.

Ms Bishop: "I think I have a role helping people to adjust to disability and long term illness both in terms of the patient and their families. The problem is that if you say this they (the district nurses) say 'But we do that'. But the personal thing and the coping bit isn't touched. The same is true of bereavement".

Some months later the social worker commented:

"It's the 'straight' nurses I don't feel happy about. The things they refer are very particular and they have distinct ideas about what problems I should alleviate. For example one old lady was referred to me because the district nurse

was worried about the lack of heating. They said they'd get moving on it right away but they didn't. I was really dissatisfied, one because they see my role in purely material terms and two because when the Gas Board didn't act it was seen as a failure on my part". (Speaker's emphasis).

The health visitors differed from the district nurse and midwife insofar as they: held a more extended definition of the social worker's role; referred a wider range of cases to the worker; and were prepared to negotiate a division of labour with their social work colleague.

The social worker engaged in politicking, bargaining, argument and diplomacy with certain groups and individual participants and invoked such techniques as appeal, apology and pressure:

"Look, I'm really sorry but I can't make it to the meeting this morning. I really have to finish writing up my case notes. I've put it off for weeks now. I'll try to attend next week".

"I don't think there's much I can do with Mrs Smith, she doesn't want to discuss the drink problem. The other problems can't really be tackled until she does something about the drinking. I'll go in to see her again next week but if the situation's the same I'll withdraw until the next crisis".

In exchange for what the social worker regarded as reasonable behaviour on her part she hoped that medical staff would relax their demands for her services, and that they could be persuaded to accept her definition of the patient and her role.

Tapping External Power Bases

On a number of select occasions the social worker turned to actors whose power base rested outside of the health centre. Thus, when faced with secretarial and reception staff (Health Board employees) who were

unwilling to service her administrative and clerical needs she turned to the Health Board, and her administrative and executive office in the social work department in an attempt to 'bring the secretaries into line'. On another occasion, when faced with an unremitting demand for her services, the social worker turned to her senior who decided that she would have a moratorium on referrals from the health centre.

The social worker turned to outside agents in the expectation that they would be able to cope with the contingencies which arose in the centres, that they would act to legitimate the decisions she had reached and that they would get decisions made where no action might otherwise have taken place. While the authority system of the Health Board and the social work department may have conferred a good deal of power to the Health Board District Manager and within the social work department, the executive social work officers, they had little impact on the decision process within the centres. The social worker's attempt to gain supremacy by drawing upon the power and influence of external services was in the main unsuccessful. Rather, the involvement of outside agencies in what were defined by the participants as local, internal, affairs led to increased tension between the interested parties.

Disengagement

The social worker's final solution to the problem of control over her work and her role in the health centre setting was to disengage from the settings and reduce her contact with the majority of its actors, removing herself from the medical milieu. This strategy ranged from complete physical withdrawal from the centres, to the worker's failure to follow the rules and procedures which she herself had introduced for

informing staff of her presence within or absence from the centre. The worker also used the split-post arrangement as a form of defensive cover. The most extreme instance of disengagement occurred when the social worker withdrew her service from Centre A to take up a full time appointment in Centre B. Another critical feature of this technique was the manipulation of her timetable; taking days off; prolonging coffee breaks; attending specialist seminars and courses of training. All such techniques separated the social worker from her colleagues for a limited period of time allowing the worker to control the demand for her scarce resources. The social worker avoided open conflict and confrontation with the doctors by accepting self-imposed restrictions on her activities (capitulation): she defined herself out of certain roles and areas of work in cases which the practitioners' definition of the situation might differ markedly from her own, e.g. by not acting as mediator between certain doctors and their patients, by not representing the patients' interests to medical staff, and evaluating the performance of her colleagues. Such strategies were to cause much bitterness amongst medical and social work personnel as her disengagement was seen to be at the expense of her colleagues.

The social worker justified her decision to disengage on the grounds that direct work with patients was her primary task and that the ultimate success of the programme rested upon what she could do with and what she could do for the patient population. She therefore became preoccupied with problems of workload and controlling her workload, case management and closure at the expense of considering and dealing with the organisation of the health centres, and the area team, and the way that the settings worked.

It is possible to argue that her decision to focus at times almost exclusively on working with individual clients as opposed to taking an interest in the social organisation of the health centres is a product of her training and experience. Roberts (1982) writing about the place of organisational theory in social work practice argues:

Social work's traditional focus of interest on the individual, while it led to developing ways of communicating with other workers or disciplines at an individual level, delayed the growth of interest in the collective context it was based. (p.15)

It is apparent from the social worker's actions and comments that she did not accept the legitimacy of the doctor's influence and control over all aspects of her work. Nor it seems was she particularly concerned or believed that they could or would sanction her when she refused to satisfy their demands for contact control, keeping the social worker in relationship. By disengaging from contact the social worker effectively foiled the attempts made by practitioners to extend their control by inclusion (Tannenbaum, 1968), harnessing the social worker to their task. Nor, in the final analysis, were the doctors able to effectively monitor and control the content and substance of the social worker's work with patients. By controlling and restricting the amount of information she passed to the GPs about her work with clients she effectively worked beyond their control. The social worker's work was neither objectified nor external.

This approach to medical dominance carried certain penalties for the worker. Most of the measures at job control undertaken by the social worker were reactive rather than proactive. That is, the social worker tended to adopt strategies which were manipulative and geared to

minimalising the impact of the doctors on important decision issues. The social worker never confronted the doctors with the conflicts and contradictions which characterised their respective positions over key decision issues. In addition the social worker's personal power within the medical setting was never fully developed. Her ability to influence the doctor's ideas, beliefs and perspectives of the patient and herself were marginalised. Finally the social worker's tactics and strategies resulted in a greater degree of conflict over the social worker's 'commitment' to the centres. This in turn was related to the attempts made by certain practitioners to introduce more coercive forms of authority over the social worker.

A number of medical sociologists (Mechanic, 1968, Strauss et al, 1969) and organisational sociologists (Crozier, 1963, Pfeffer, 1981) have argued that lower level subordinates often wield power within the organisation disproportionate with their position within the organisation's hierarchy. Mechanic, following the work of Thibaut and Kelley (1939) argues that power is closely related to dependence. 'To the extent that a person is dependent on another he is potentially subject to the other person's power'. He goes on to argue:

The most effective way for lower participants to achieve power is to obtain, maintain and control access to persons, information and instrumentalities. To the extent that this can be accomplished lower participants make higher-ranking participants dependent upon them. Thus dependence, together with the manipulation of the dependency relationship is the key to the power of lower participants. (pp. 421-422).

The Power of Subordinate Workers: An Illustration

An example of the power of lower ranking participants may be found in the present study in relation to the social worker's relationship with the receptionists and secretaries employed by the Health Board. It was agreed before the start of the attachment that the social worker's secretarial and clerical needs were to be met by the existing Health Board staff. In Centre A the worker was provided with secretarial support by the medical secretaries on a rota basis, while the reception of social work patients was dealt with by reception staff. In Centre B the social worker was delegated a full-time worker who dealt with all of her clerical and administrative needs. The introduction of the social worker into the centres added to the not inconsiderable burden of work generated by medical staff.

The worker's relationship with Centre A administrative and clerical staff was fraught with tension and conflict. The social worker entered

an arena which had a history of conflict between medical staff on the one hand and health board employees on the other. Briefly, prior to the introduction of the social worker certain practitioners had been critical of the performance of their support staff. From the point of view of the employees the expectations that medical staff had of their role, and the behaviour of the doctors toward the secretaries and receptionists, was unrealistic and unreasonable. This conflict was to reach a water-shed when, some six months prior to the commencement of the social work attachment, the Chairman of the Health Centre Users' Committee called for an organisation and management study by the Health Board of the working practices of its employees in the hope that they would be 'brought into line'. The approach to the Health Board and the fact that the recommendations of the O and M study were only partially implemented created additional tension and strain between the two groups. Further the Health Board personnel, alienated from the organisation, were able to turn the results from the study, particularly that part which dealt with their job description, to their advantage; they claimed that the work generated by the social worker was not incorporated within their job description, i.e. it was not 'medical work' - and as such did not form part of their formal function.

The secretaries and receptionists also felt that they were treated in a somewhat cavalier fashion by the attached worker; she appeared to take staff for granted and failed to appreciate the novelty of the work she generated. For example, secretarial staff in both centres complained of the length of the worker's letters and casenotes and the unfamiliar terminology she employed.

Finally, the support staff were of the opinion that the social

worker failed to avail herself of the opportunity to spend time in the reception area in order to understand the nature of their work and to become familiar with the staff on a personal level.

In an attempt to facilitate the passage of information between the worker, the reception staff and the patients, new rules were introduced whereby it was agreed that the social worker would keep a 'day book' or diary. This arrangement occasionally broke down either when the social worker failed to record her daily agenda or staff failed to consult the diary. This resulted in episodes of patients being turned away from the centre or misinformed of appointment dates. Such lapses in communication simply served to fuel the frustration and tension experienced by both the reception staff and the social worker.

This relationship deteriorated to a point that the social worker issued a formal written complaint to the Health Board, the Chairman of the Health Centre Users' Committee and her senior supervisor regarding the support she received from the support staff. The substance of this complaint centred upon:

- i) the resistance of clerical staff to the work generated by the social worker and the subsequent delay in the typing of formal correspondence, agendas and casenotes;
and
- ii) the failure of reception staff to pass on messages to the worker and/or her clients.

This particular strategy did little to improve the already strained relations, not least because the attached worker had approached the health centre administrator on only one occasion to register her

dissatisfaction. More importantly, this strategy of control was not successful when put into practice. On the basis of their knowledge of the rules of the organisation, how it worked, and their conditions of service, the secretaries/receptionists continued to manipulate the system and define what was legitimate and appropriate work for their role. They were, therefore, able to deflect or alter the changes to their work associated with the introduction of the social worker and subvert the new rules. They presented the social worker, and her superiors, with various reasons why her work could not be carried out by presenting the higher level participants with rules and complexities which they were unable or unwilling to challenge or evaluate.

The Latent Power of the Attached Social Worker

It can be argued that ideally the social worker occupied a position in the structure to exercise considerable power and influence within the health centre setting. To an extent all of the health centre staff were dependent on her because she controlled access to information about other organisations and how they worked. She had knowledge of persons working in other organisations including contact points; and she had knowledge about the norms and rules of various organisations. The social worker's knowledge of and access to these and other human, material and financial resources should ideally have acted, according to Mechanic (1967) and Whittington, (1983), as a useful currency for negotiation and should have enhanced her bargaining position in the decision process.

The social worker's hand should also have been strengthened, given the majority of the participants recognised and required these resources in order to get their work done. In addition, by their own admission,

the participants had difficulty in getting resources elsewhere, i.e. the social work department. In short, the social worker's control over these resources and instrumentalities made her useful to others.

Mechanic might also argue that the social worker occupied a favourable position to command adjustments, accommodations and concessions from her health centre colleagues, as a result of her location and position within the centre. The social worker had the opportunity to interact with all of the participants and she could have occupied a central position both in the formal and informal communication networks of the health centre. Yet there was little evidence that the social worker enhanced her power or that she made a strong impact on the decision process.

In order to exploit these resources of power it is necessary for the individual to be aware of their ability to exploit these resources and they must be prepared to use them. The data suggest that the social worker was either unaware of the power resources associated with her position within the structure or unwilling to exercise power in her relationship with GPs. She chose instead either to use manipulative techniques or to withdraw from contact with her co-workers.

Approaches to Power in Social Work

A number of explanations have been put forward by various authors to explain the apparent hesitancy of social workers to confront and use power in the organisations in which they work. Some writers (Foren and Bailey, 1968; Rees and Edwards, 1973; Simpkin, 1979; Day, 1981) observe that the subject of power, authority and control has been widely discussed and is often dealt with briefly in books about social work.

They argue however, that this range of interconnected issues tend to be treated in an ambivalent fashion by social workers. Day, for example, observes that "authority" has been something of a 'dirty word' in social work, because it conflicts with the cherished social work values of participation and self-determination. Thus, emphasis is placed in the literature on the 'caring' rather than the 'controlling' elements of social work practice. These authors might therefore argue that the attached social worker's approach to matters pertaining to power, authority, control and conflict within the health centre setting, and her reliance upon more manipulative tactics such as disengagement as a means of work control, belies an ambivalent attitude to such matters picked up during her early period of professional socialisation.

Other analysts of the social work scene explain the non-confrontational approach adopted by social workers, particularly in relation to medicine, as a product of the social worker's early training experience. However they locate the problem in deficiencies in social work education which leave social workers ill-equipped to deal with power in organisations. Roberts (1982), for example, argues that social work training does not teach social workers about the way organisations are formed, how they are structured and how they operate. Thus, neophyte social workers come unprepared and ill equipped to deal with the reality of the work setting. Whittington (1983), on the other hand, takes a slightly different view and suggests that the present training of social workers does not teach them enough about the strategies and tactics of negotiation and work control. For this reason social workers may wish to avoid direct confrontation with their medical colleagues and avoid contests for power and control over the work setting.

Another explanation for the pattern of power relationships I have described is advanced by Huntington (1981) who argues that the non-confrontational approach of social work to medicine is a consequence, or artefact, of differences in the socialisation of a predominantly female social work and male medicine which reflects the sexual division of labour in contemporary society. Certainly the arguments described above provide useful avenues to follow in future studies of power relations in the multi-disciplinary health centre setting.

What is of significant importance to our understanding of the power relations within the health centres under discussion is, I would argue, the view that each party brings to their encounters with one another about the balance of power between occupational groups. Within the medical setting the social worker, in common with other subordinate workers, perceived herself as having little power. The social worker commented some weeks after ordering a moratorium on referrals:

"I don't know what to do. No matter what I say or how I try to handle it they (the GPs) just seem to ignore it. I ask them to refer patients to the area team and they just carry on referring the patients to me".

After a health centre--social work meeting, the social worker commented:

"It took me ages to convince Sally (an area team social worker) to come to the meeting because Dr Lamb had a case she wanted to discuss with her. So what happens, Dr Lamb doesn't show up and then fifteen minutes after the meeting has ended she (Dr Lamb) comes up to me in the hall to ask me about the case, as usual".

On other occasions when the social worker was about to leave one centre for home she was summoned to the other centre to attend to a

'crisis they had on their hands', a command to which the social worker responded with some acrimony.

The social worker felt that she had little effect on the decision making process in the health centres whereas the doctors appeared to the social worker to be capable of impacting on decisions. Further, she had little belief in her position to be able to be a powerful advocate for her own views. For this reason she chose to withdraw from contact with the doctors and the other participants in order to avoid open confrontation and to escape their influence. Like Goldie's psychiatric social workers, the attached social worker handled the conflict in such a way as to reinforce the unequal structure of power and authority relations within the medical setting. The social worker reinforced through her actions the legitimate authority of the doctor against her own interests.

SUMMARY

In this chapter I examined some of the issues to do with order and control over the work of the social worker. Observing the events, the researcher was struck by the multi-dimensionality, simultaneity and unpredictability of the social worker's role within the centres. My field notes for the latter stages of the study are replete with examples of the kind of constant pressure the social worker had to face. For example, while attempting to have lunch between home visits to the clients she could expect to be accosted by health centre personnel who wished to make an 'informal referral', discuss a patient they had in common, or to ask for advice and information on some aspect of welfare legislation. These lunch-time encounters were often interrupted, for

example, by patients such as the distraught single parent who threatened to abandon her child 'unless the social worker took the child into care'.

It is difficult to comprehend the importance of the events and incidents, occurring on a daily basis, which the attached worker had to accommodate. She was after all a relative newcomer not only to medical practice in general and the health centre setting in particular but to the field of social work practice. Having qualified six months before joining the centres and with six months' experience of working as a locum social worker in the local psychiatric hospital, the relatively naive newcomer was expected to adjust to and deal with the myriad exigencies which arose as she attempted to secure a role within the two health centres and the local social work department.

The physicians were found to use a variety of analytically distinct tactics and strategies geared to enhance and maintain their power and influence over the social worker and other subordinate workers. It was clear that the power of medicine in these settings was derived from a variety of sources, not simply their structural position in the hierarchy of medical authority, although this undoubtedly formed part of their power base. The GPs enmeshed subordinate workers in a system of formal and informal agreements, based, at least in part, on their ability to provide rewards, or inducements, which were desired by the para-medical and lay workers. In addition some of the GPs were adept persuaders and politically skilled negotiators who engaged subordinate workers including the social worker, in contests which impacted on the decision process. Some of the practitioners were however more politically skilled than others, in the sense that they were generally

more successful at persuading others to accept their communication as the basis for their own action and ideas. The data also suggests that the power of those who were consistently successful at persuading others to accept their views and their definition of the situation was transformed into personal power and, in some isolated cases, competent authority; that is authority based on the recognition by the other members of the practice team that the individual doctor was especially knowledgeable and especially skilled.

I mentioned earlier in this chapter that when the social worker took up the post she discovered, much to her disapproval, that the health centre participants held certain normative expectations about her role as attached worker which were at once taken for granted and non-negotiable, e.g. that she would chair the health centre--social work meetings, that she would operate an 'on-demand' service both for patients and staff, that she would deal with problems which were exclusively practical and concrete in nature. Furthermore the social worker proceeded to fulfil their expectations although in doing so she seemed to act against her own interests and preferences. This process may also be seen as an exercise of power over the social worker; by treating certain roles as 'given' the physicians, along with the para-medical workers, ensured that unacceptable issues, those issues which they had no intention of debating, were kept off of the political agenda (Lukes, 1974). The medical practitioners pre-empted the social worker from making demands which could become a political issue and stopped the social worker from achieving the outcomes she preferred.

In summary, the power of the medical practitioners in relationship with para-medical and lay staff was derived from structural, collective

and individual resources and their willingness to engage in strategies which increased and maintained their power within the medical setting.

In addition, the different forms of power relationship tended to interact in combination. The power strategies which each occupational group employed mixed and merged into each other. For example, authority by inducement could easily be transformed, and be experienced by the subordinate, as coercive power. In addition the doctors would actively resort to more coercive measures of power and authority when alternative forms were tried and failed. For example, as a result of their failure to engage the social worker in various sub-units of the organisation some practitioners were explicit in their refusal to supply the social worker with interesting cases until such time as she complied with their wishes (see quotes pp 254, 255). Thus rather than there being a tendency toward a stable power relationship between the different occupational groups based on a hierarchy of legitimate authority, the relationship between the doctors and the social worker in particular was marked by variety and change in the power relationship in part as a consequence result of intentional decisions and in part as a result of unforeseen or unanticipated consequences of their decisions.

The power and the influence of the doctor was not, however, always effective. That is, his power tended to be limited in comprehensiveness to specific decision issues and situations. While they were able to command and control the organisation of the social worker's work in the centre they were unsuccessful in their bid to monitor and control the content and substance of the social worker's work with patients. Nor were they able to maintain contact control over the social worker; they were unable to draw the social worker into the personal and professional

relationship they wanted, and once there, keep her there.

The daily practice of the social worker involved her in attempts to gain control over her situation while minimising the control by others, notably the doctors. In an attempt to gain control over her work the social worker eschewed confrontation with the doctors and chose instead to use more manipulative techniques including; accommodation, socialisation, negotiation and, most significantly, disengagement. By and large the social worker did not rely upon association, developing good personal relations with medical practitioners and establishing a sense of mutual obligation or coalition, mustering the support of other groups where common interests and position had been identified, in the political contests that took place within the centres.

The social worker, through the use of self-imposed restrictions on her behaviour and by avoiding open confrontation with the doctors reinforced, through her actions, the internal distribution of power within the centres. As a result, she had little influence on the practitioners' definition of the situation, the patient and the social worker. The existing social order within the centres was, therefore, preserved and little affected by the social worker's introduction into the medical setting.

The power relationship between the physicians and the other health centre staff differed in some respects from that of the GP--social worker relationship. Pairs of health visitors were attached to pairs of doctors and they received referrals only from those doctors. The community psychiatric nurse also had a relatively narrow source of referrals; most of their work was generated from the psychiatric team, particularly the GP/Psychiatrist. The other subordinate workers were,

therefore, more dependent on a single source of referrals whereas the social worker's work was generated from the total body of GPs and attached para-medical workers. For this reason the para-medical workers were more interested in keeping in relationship with those upon whom they depended and, of necessity, they were more interested than the social worker in adopting and maintaining medicine's rules for social interaction. When they learned that the social worker refused to participate in health centre events and that she avoided the health centre and its sub-units they realised that their relationship with the GPs, and the adjustments they had made to the GP, were not going to be threatened by the introduction of the social worker into the medical setting.

CHAPTER SEVEN

INTRA-DISCIPLINARY RELATIONSHIPS AMONGST SOCIAL WORK STAFF

There has been little research on the choice, use and practice of outside experts and other external power resources by lower level staff in medical institutions. Yet there were a number of incidents which took place within the health centres which suggested that this idea is not far-fetched. For example, shortly after I joined the practices the health visitors became locked in a battle with the GPs over their participation in the child immunisation clinics. For a number of years the health visitors had helped the GPs screen children of the practice and had been delegated the responsibility for giving the child his injections. At the time of my arrival at the centre the health visitors were informed by the local Health Board that they were not covered by malpractice insurance to carry out these procedures and they were instructed to withdraw their service from the immunisation clinics. This led to a major contestation with the doctors whose authority to direct the work of others was under question. The doctors argued that as they had delegated the task of giving injections to the health visitors the health visitors were covered by their insurance. The nursing staff came under considerable pressure from the doctors to maintain the status quo, a request some found difficult to resist. Ultimately the nursing staff called in the Senior Nursing Officer to resolve the dispute. The outside authority carried more weight than the field work staff and in this instance she served to explain and legitimise the Health Board's decision in order to get the health visitors 'off the hook'.

Access to external sources of power were, if anything, even more important to the professionally isolated attached social worker. Firstly, as I indicated in the previous chapter the social worker relied upon her senior social worker to legitimate certain political decisions which would not have otherwise been taken, e.g. to call a moratorium on referrals and to withdraw from one centre to take up a full time post in the other. Secondly, she was dependent on her senior social worker for casework supervision and support to cope with the varied exigencies and demands which arose from working in a medical setting. Thirdly, she relied upon her area team colleagues to achieve her operational objectives and to satisfy the Department's policy e.g. building closer links between the centres and the local authority department. For this reason an understanding of the social worker's relationship with her colleagues and superiors is of some importance to an understanding of the global process of negotiation and bargaining within the medical setting.

Staff Supervision in Social Work:

The Function of Supervision and the role of the Staff Supervisor

The term supervision as it is used by social workers is not unambiguous: in an investigation of social service teams (DHSS, 1978), the researchers found that whilst social workers apparently shared certain general views about the nature of supervision there was no common definition of its purpose.

Supervision as it is generally defined refers to a managerial act in which the work of the individual (the subordinate or supervised) is scrutinised, directed and to a certain extent controlled by a superior (the supervisor) occupying a position of authority. However, the DHSS

report concluded that there appears to be a great deal of confusion amongst social workers about the managerial component of the supervisory process. At one extreme there were those who preferred to use the term consultation rather than supervision and 'thus deny that the process involved any management of their work by seniors'. At the other extreme there were those who were in no doubt of the authority of the supervisor to direct and control the work of his or her subordinate. The rest of the respondents were said to occupy a confused and uncertain middle ground between the two extremes.

The researchers also reported that social workers tended to define supervision as a process of consultation between social service staff, not necessarily with someone in authority, about cases and methods of work. The purpose of such consultation is to provide the worker with 'support, advice to be considered but not necessarily acted upon, and further professional development'. It is inferred from this view that social workers tend to emphasise what they consider to be the developmental and enabling functions of supervision and not control: supervision is meant to provide the workers with the opportunity to enhance their knowledge and understanding of the client and the practice of social work.

A number of analysts of the social services have expressed concern about the ambiguity and uncertainty of 'supervision' as defined by social workers. This concern stems not least from the fact that supervision is regarded as the principal instrument by which the individual worker is made accountable to the organisation (DHSS, 1978; Hay and Rowbottom, 1977; Pettes, 1979). Indeed there are those who

argue that the managerial, developmental and analysing components of supervision are so inextricably interwoven that to separate them into component functions is to create an artificial distinction.

8.5. Supervision must have two main purposes; to establish the accountability of the worker to the organisation and to promote the worker's development as a professional person. Since accountability is concerned not only with whether a task is performed but also with the quality and standard of work, the two purposes are practically and conceptually linked. (DHSS, 1978, p.200).

In other words, the two objectives of supervision, (i) enabling the worker to develop their professional skills and expertise while (ii) linking the worker to the organisation's system of accountability, is realised when, and only when, the supervisor exercised some degree of managerial control over the individual and his work. The supervisor is thus expected to:

- (i) Advise and give direction to the worker: recommend alternative ways of conceptualising problems and encouraging the worker to achieve a deeper understanding of the client and his/her problem. The supervisor may, in certain situations, attempt to focus the worker's attention on new, or alternative strategies of intervention and methods of work. Alternatively the supervisor might simply act to provide the worker with support and encouragement as they carry out their tasks and duties.
- (ii) Take part in the management of the worker's case and workload: adjust the number of cases allocated to the

worker, prescribe the types of cases to be allocated to the worker, and define the type of work which, in his judgment, should be carried out by the worker. Further, the supervisor is expected to delegate certain powers of discretionary decision making to the worker on the basis of his assessment of their level of competence and expertise.

- (iii) Survey and evaluate the worker's progress and performance as a professional worker: monitor the worker's progress as a practising social worker and examine their performance in relation to their work with clients (individuals, families or groups). The supervisor should, ideally, ensure that the work which has been prescribed is being done in accordance with the supervisor's perception of what should be done and that it is done to an acceptable standard.

These represent the principal tasks associated with the role of the casework supervisor. The supervisor may carry out a range of additional functions including; acting as an interpreter of departmental policy; linking the administrative and fieldwork segments of the organisation; assisting in the selection of new appointments to the organisation; offering career guidance to workers and so on. (Hey and Rowbottom, 1977; Pettes, 1979).

The Supervision of the Attached Worker - An Overview

The executive officers and the area team managers recognised that there was a need to ensure that the attached worker received adequate supervision. Although the post was sponsored by the Region (the post was derived from the Department's and not the area team's establishment)

it was argued that supervision should be furnished by a senior member of the area team. In effect the attached worker was expected to 'slot into' the organisation's system of line management.

Unlike her colleagues, however, provision was made for the worker to receive additional consultation: due to the innovative nature of the post, and the worker's relative lack of experience of working with patients in a medical setting, the two executive officers agreed to act as consultants. To this end, monthly consultation sessions were held within the centres to which the worker and her supervisor were invited, and expected, to attend.

Once the attachment was under way it became apparent that the worker found it difficult to discriminate between the consultation and supervision provided by the executive officers and senior staff. For example, in the absence of her supervisor the attached worker used one consultation session to discuss matters pertaining to "casework". Following this episode guidelines were established which restricted consultation to discussions about: (i) broad issues of "health and social work" and (ii) issues related to the development of the post within the centres. Unfortunately this simple prescription for action was found wanting when put into practice.

Supervision: The First Phase

It has been argued elsewhere in the literature that for the newly qualified worker the first year or so of practice is the most difficult and traumatic period of their career (Cherniss, 1980a, 1980b). Some authors (Armstrong, 1979; Cherniss, 1980b) have attempted to capture the

experience of individuals as they make the difficult transition from student to worker by reference to the evocative metaphor "reality shock".

It is conceivable that for workers taking up posts in secondary settings (e.g. health centres, schools, hospitals) supervision is especially important. Not only does the worker have to cope with the stress associated with a new career, she will also confront problems which are associated with, and emanate from, providing social work in a secondary work setting. As I have shown in earlier chapters the attached worker had to:

- (i) establish herself in three different work settings, each with its own set of goals, norms of social interaction and practice ideologies;
- (ii) learn a new language and ways of conceptualising problems;
- (iii) cope with the strained relations existing between the social work department and with the health centres.

Despite these and other difficulties the attached worker received little help and support from her supervisor during her first three months of practice. Rather than acting as a source of support to the worker the supervision process was itself a source of conflict.⁽¹⁾

According to the worker, supervision during her first three months of practice was virtually non-existent. Her (first) supervisor appeared disinterested in her job, provided little support in the form of technical advice and information, and tended not to create any opportunities for the worker to make contact as the need arose.

Meetings which were arranged for supervision were often cancelled, and when they did occur the discussion invariably centred on matters pertaining to casework with clients. Her first supervisor played only a marginal role in directing the worker into her new post. Nor was he instrumental in helping the worker to resolve some of the difficulties she encountered. It is conceivable that at the time the senior's attention was distracted by other, more immediate problems. For example, during his brief stay as the worker's supervisor, the senior was concerned not with expanding his workload, but rather with reducing his work in preparation for leaving the area to take up a post elsewhere.

After three months the supervision of the worker was taken over by the area team leader as an interim measure until another senior could be found. This temporary solution to the problem was to last for another three months: it was not until the worker had been in post for six months that a senior social worker took over the long-term supervision of the attached worker. Given the rapid turnover in staff occupying the position of supervisor it was not surprising that the worker reported that she felt exposed and "out on a limb". Indeed, as I mentioned in the previous chapter, as a result of the strain of working on this innovative experiment the worker considered resigning from her post.

The worker lacked a point of reference within the area team, one definite person who was accountable not only for dealing with her work but someone who attended to her particular needs. As a result the worker's morale and motivation were to suffer, eventually she was to adopt a 'survival mentality': becoming resigned to the conditions of her work and learning to 'get on with it'. Later she was to develop a working relationship with her third senior who took an interest in and

made a commitment to the worker and the programme. This relationship was not, however, without its difficulties.

Problems of Supervision: The Second Phase

In the absence of consistent supervision by one senior, the worker adjusted to her situation and grew accustomed to working in a relatively autonomous fashion beyond the managerial control of the supervisor. By the time her third supervisor was designated the worker found it difficult to take seriously any assessment of her work by a senior member of staff whom she saw as a senior colleague and not as a manager. A number of factors may account for the worker's perspective: First there is the general problem of the uncertainty surrounding the purpose of supervision and the role of the supervisor in social work. Second, due to the constant changes in personnel occupying the position of supervisor the participants had little opportunity to establish a pattern of supervision, e.g. defining what they could expect of one another, agreeing on the scheduling and frequency of meetings, and so on. There were additional factors which were identified that made the supervisory process problematical. These include:

The structure of the attachment: Social workers, among other front line human service workers, are accorded a good deal of discretion in the decisions they make (Smith, 1979a, 1979b). Social workers are required to make judgments which are to a large extent unprogrammable. As a result they work beyond the immediate control of their managers and administrators. The outposted worker was physically distant from her supervisor. As a result the work within the centres was, by and large, hidden from the immediate gaze of the supervisor. Her supervisor was denied the opportunity of observing the worker's performance with her

clients at first hand and engaging the worker in informal, spontaneous, supervision as the occasion arose, which, according to Hey and Rowbottom (1977), has come to characterise the supervision process in British social work.

The supervisor was also denied access to other secondary sources of information upon which supervision may be based. The attached worker's records on active cases were kept on file in the two health centres.⁽²⁾ These records were transferred to the area team, in an edited form, only upon case closure. As a result of these restrictions, the supervisor came to rely upon three principal sources of information about the worker and her work:

- (i) the formal supervision sessions;
- (ii) formal reviews when the worker was obliged to submit a written report, e.g. panel meetings, social inquiry reports, and adoption and fostering reviews;
- (iii) monthly consultative meetings with senior officers.

Role Ambiguity

Formal supervision was, ideally, to have formed the mainstay of the supervisory process. The senior social worker was to report, however, that his formal contacts with the worker did little to extend his knowledge of and information about the worker and her work. His so-called subordinate appeared unwilling to discuss either her work with clients or her job within the centre. Casework supervision was further hampered by virtue of the fact that discussion centred only upon those cases the worker chose to present to the supervisor.⁽³⁾ Put another way, the attached worker appeared to question, and ultimately deny, the

assumption that the supervisor's role carried certain managerial functions; she denied that her supervisor had the right to prescribe and evaluate her work, despite his expressed doubts about the consistency of his subordinate's standard and quality of practice:

Mr Carson: "I finally found out what she was doing after we took some kids away on holiday. I had the chance to chat with her after the kids were in bed. I was surprised at how glibly she discussed her cases: it seemed to me that she hadn't really thought about what she was doing. She hadn't really thought about the problems and what she was doing with her clients".

Given his reservations about the worker's practice performance the question may arise as to why the supervisor did not exert his authority and exercise a greater degree of managerial control.

The senior's supervisory behaviour reflected the confusion and uncertainty surrounding his position. There was a lack of clarity about his authority to prescribe and assess the attached worker's work and his authority to sanction the worker. The post was defined by field work staff as a 'Regional' post. It was therefore assumed that the locus of authority rested directly in the hands not of the senior social worker but in the hands of the department's executive officers and the attachment steering committee. There were, in addition, a number of systemic factors which served to reinforce this view. First, executive officers were actively involved in the operation of the programme. Second, the attached basic grade worker often dealt directly with executive officers, by-passing her line management. And, finally, in at least one instance an agreement which had been made with the area team was later overturned by an executive officer without consultation with the field level staff.

At no stage of the programme did the department offer their professional staff a clear and definitive statement of the way in which authority was to be distributed amongst social work staff. The worker's accountability, to whom and for what, was never fully explicated. Nor did the department and its representatives spell out the organisational roles and expectations that the worker and her supervisor should have of one another. In the absence of such guidelines the professional staff lacked a framework within which they could work with one another. Moreover, the supervisor lacked a clear idea of what he should, and could, expect from his subordinate. In this situation managerial accountability was ambiguous and diffuse, and the attached worker was able to exploit the situation in order to work in a highly autonomous fashion. From the point of view of the worker, the high degree of autonomy was one of the most positive features of her job. She found that she was able to modify her role in significant ways without her supervisor's knowledge or interference.

Ms Bishop: "To me it's the autonomy (the advantage of the post). Being able to decide which cases I pick up; to decide what I think is appropriate to do in a case; deciding whether or not to attend meetings. That sort of thing. In part this is related to this post being a regional post. That really makes the job. I could run it differently, in a different way, if I wanted to. If I'd been a basic grade social worker in an area team it would have been different. It would have been more structured and I'd have been told what to do".

Supervision in Practice

Ideally the supervisor's role should have included a planning

element - helping the worker set priorities and establish reasonable goals, suggesting ways of handling difficult problems, gearing the work to match the worker's level of skill and expertise, and assigning work according to the capability of the supervisee. In practice, however, the attached worker presented her supervisor with what she had done in terms of her casework fait accompli.

Mr Carson: "I supervise her regularly which means saying 'Yes, what you've done is O.K.', after the event. Planning is rather, ah, planning isn't appropriate to the way she operates. I guess you have to change your ideas about supervision if you supervise a person in a post like this".

In addition it is clear from the senior social worker's account that he had little part to play in determining how much discretion the worker should be awarded, how she could be assisted to put this discretion into practice; and determining the point at which her actions had to be controlled and/or sanctioned. The senior supervisor felt that he had little option other than to "rubber stamp" the independent decisions made by the worker.⁽⁴⁾

Although the senior was to play a relatively marginal role in casework management, he was able to exercise a greater degree of managerial control over the development of the worker's caseload.

The supervisor was able to tap a number of different sources of information which gave him insight into the amount of work the attached worker was doing, e.g. monitoring the attached worker's application for overtime payment, and informal discussion with the worker. On the strength of this information he argued that the attached worker have a complete moratorium on referrals from the centres. Later, he was to

recommend the major change in the programme's organisational design: the worker was to be withdrawn from Centre A in order to take up a full-time post in Centre B.

In addition the supervisor became increasingly involved in what he defined as the "politics" of the attachment programme. In the first instance this took the form of providing the worker with support:

- (i) by acting as the worker's point of reference within the area team;
- (ii) by acting as a buffer between the worker and individuals and groups who, in one way or another, put pressure on the worker. In addition he helped to resolve disputes between the worker and others in a constructive way; and
- (iii) by acting as the attached worker's representative within the area team, representing her interests and championing her cause within the area team, helping to disseminate information about her post, clarifying the purpose of the attachment to her colleagues and peers and, on occasion, attempting to change the attitude of team members to the programme in a positive direction.

These were, by and large, continuous roles which the supervisor performed throughout the period of investigation. As the supervisor's stock of knowledge about the worker and her post increased he became increasingly involved in steering the programme's course of development. More specifically the supervisor assumed the role of:

- (iv) diagnostician, conceptualising what he considered to be the

principal problems and pressures facing the worker operating from two centres;

- (v) planner, drafting a blueprint of changes to the attachment which were designed to relieve the worker of some of the pressures arising from her job while promoting the programme's success;
- (vi) co-ordinator, once his plan had been ratified by his superiors, orchestrating the change in organisational design so as to affect co-ordinated change in the attachment.

The supervisor expressed unwelcome 'surprise' at the way in which his role evolved. As a supervisor of a new post he felt that he could legitimately expect to have received considerably more support from senior officers in the form of technical advice, guidance and rapid decision-making.

The Relationship between Professional and Executive Staff

From the point of view of both the senior supervisor and the worker the support that they required from the executive was often lacking. Two months after taking up his duties the supervisor observed:

"The feeling we have is that we've been abandoned; they don't seem to take an interest in what Jane's trying to do here and what she has to put up with. If I'd taken no interest in her or Jane had continued to feel the way she did when I first took over she might have quit. Then where would they have been?"

Despite their monthly meetings with executive officers the professional staff became alienated from the central administration.

Their sense of alienation and professional isolation reached its peak during the period when the programmatic changes in the attachment were introduced for discussion. At this time the supervisor and the worker turned to the executive officers of the steering committee: for advice on their recommendations; for a rapid decision on their proposals; and for support when they faced the hostility of certain area team personnel who were, and had been, critical of the programme.

Unfortunately, at a time when the professional staff were in need of positive direction from above the attention of the executive officers was diverted elsewhere. Firstly, the attachment steering group, the group responsible for setting up the programme, was disbanded and replaced by a 'social work and primary care group', under a new chairperson. When the supervisor referred their proposals for change to a higher authority they encountered what amounted to a power vacuum in the decision-making structure of the Department. Second, another experimental attachment was at the time in the process of being launched elsewhere in the Region. Consequently the attention of executive officers was focussed on getting the new attachment off the ground. This shift in attention was interpreted by professional staff not as a temporary change in the senior officers' priorities, but as a loss of interest:

"Jane and I have been invited to the newly constituted (primary care) group to discuss supervision, consultation and support. It's as if they've lost interest in Jane. Now they have a new toy to play with".

Positional conflict thus came to characterise the relationship between central office executives and their professional fieldwork

staff. (5)

Neither the supervisor nor the worker confronted senior staff with their grievances and uncertainties. A number of factors may account for the hesitancy of the professional staff to use the consultation sessions for the broad purpose for which they were originally intended. Given the innovative nature of the programme the senior supervisor in particular appeared to accept, at a commonsense level, that many of the problems he encountered were part and parcel of a new programme, e.g. that they represented "teething problems". Further, as the supervisor was unsure of the way in which authority and accountability were distributed amongst staff he appeared to be of the opinion that it was up to the worker and himself to adjust to the exigencies arising from the programme. Finally, it is conceivable that tension and strain between fieldworkers and executive staff reflected socially structured tensions existent within large-scale bureaucratic organisations. (See, for example, G. Smith, 1980; Barclay, 1982). Positional conflicts over the priorities, goals, and ideologies between the administrative core of the organisation, and its professional staff located at the organisation's periphery were a fundamental feature of the attachment process.

The Worker and the Area Team

Aside from the support of her supervisor and senior officers the attached worker was, ideally, to have received support from her area team colleagues. First, social interaction between colleagues was meant to have helped the worker to acquire a better perspective and understanding of the client and their problems. Second, her colleagues

were to have acted as an informal source of technical information and practical advice. Third, contact with her colleagues was to have supplied the worker with a professional frame of reference so that she would not feel professionally isolated when outposted in the medical settings. Fourth, the worker relied upon the backing of her colleagues in conflicts with the organisation; providing a "united front" vis-a-vis the department and/or the centre(s).

The attached worker also relied upon the area team for material support. In common with her peers working in local authority settings the worker was partially dependent on the area team for financial and material resources for her clients. In addition the worker looked to her social work department colleagues to provide cover to the centres during periods of her absence due to illness or holidays.

Ideally the attached worker was to have acted as a bridge between the local medical and personal social services. Once these links had been established the worker was to have acted as a catalyst, stimulating the growth of a closer, more co-operative, working relationship between individual workers and different groups of workers. She therefore looked to her colleagues in the area team and the centres for their support of any initiatives which she undertook to secure this end, asking them to underwrite with their action and behaviour her attempts to foster collaboration and cooperation between the local medical and social work services.

Finally, the worker hoped that her colleagues would respond positively to referrals from the centres by allocating the cases, assuming, of course, that the team had the spare capacity to absorb new

cases. On the one hand the readiness of the team to respond to her referrals would have relieved the worker of some of the burdens of her workload. On the other hand the area team could have made a positive contribution to the medical worker's evaluation of the programme. A quick response from the area team may have helped create a favourable impression of the worker and the value of having an attached worker in the health centre setting.

Collegial Support in Practice

In practice the desired social interaction between the worker and her colleagues, particularly in terms of their support, never fully materialised. Indeed, much of the social interaction which did take place increased the worker's sense of professional isolation and alienation from the department with the following results:

- (i) she chose not to use her colleagues as an additional source of advice, information and guidance except for certain specialist enquiries, e.g. advice regarding potential foster parents for her clients;
- (ii) informal, spontaneous, social interaction between the worker and the area team was minimal. The worker spent little of her time in the area office during office hours. The worker thought that it was indicative of the attitude of her colleagues toward the attachment programme that during the first eighteen months of practice only one social worker, other than her senior, visited the centre(s);
- (iii) the worker hesitated to become involved in the area team's

administrative system. At one stage the suggestion was put forward that the worker participate in the allocation meetings as a means of controlling her workload. The worker declined on the legitimate grounds that such an arrangement would be unacceptable to medical personnel. Social work staff also suggested that the worker become a regular attender to their weekly meetings. Again the worker refused on the grounds of 'pressure of work';

- (iv) the worker declined to use the team as a referral point, i.e. referring cases to the area team. Initially the worker felt that there was little point in referring clients to the team due to the shortage in manpower. Once the department had returned to its full establishment strength the worker continued to avoid using the team as she felt that there was little or no guarantee that their decision about the allocation of the patient would be taken quickly or that her referral would be allocated;⁽⁶⁾ and,
- (v) she organised and chaired the monthly social work--health centre meetings in Centre A and established, organised and chaired the meetings in Centre B. While her colleagues were reported to have supported the establishment of these meetings "in principle" their support did not extend to actually attending and participating in these meetings.

Ms Bishop: "I feel responsible for the meetings and I feel embarrassed if people don't turn up. I have a stake in making them a success. But, no matter which way I work it (at the department) nothing happens. Most of them don't show up ... No matter

what I do it doesn't make a difference. I put it to them that I could scrap the meetings. But they said they thought they were a good idea and that they should continue ..."

Of the small number of workers who did attend regularly their active participation was, by and large, limited. During the first year, a total of twenty-one meetings were held. On average medical personnel presented five cases per meeting for discussion. The social workers on the other hand brought forward only two cases for discussion during the year.

Analysis of fieldnotes suggested that many of the social workers were unable to transcend their antipathy toward medical personnel in order to provide the worker with support. That is they were unable, or unwilling, to treat the needs of the worker as a higher priority than their own personal feelings and attitudes. Further, the behaviour of the social workers tended to suggest that they had little interest in tapping the health service worker's knowledge of the clinical and social history of their clients nor were they particularly interested in developing a dialogue with health service workers on broader issues of common concern and interest.

Within a relatively short period of time (six months) the worker's relationship with her colleagues was such that she felt a stronger sense of identification with some of the participants based in the health centres than she did her colleagues and peers based in the social work department.

Ms Bishop: "I wouldn't say that I have a stronger identification with the health centres than with social workers generally: with social work generally: with social work as a profession. But

I do feel a stronger identification with the centres than I do with the area team. If I wanted to get something done then I'd turn to Dr Hall or Dr Lamb for their support".

A number of systemic factors contributed to the professional isolation and alienation of the worker. Informal discussions with senior social workers was sufficient to reveal several potential sources of conflict. The attitude of certain senior members of staff toward the attachment can be summed up as one of acute mistrust.

Differences in Personal and Professional Values

Two of the three senior social workers reported that at best they had reservations about the principle of attachment and at worst were opposed to all attachment programmes. The two seniors argued that it was better to develop social work within the context of existing local authority structures, i.e. the area team, rather than developing social work posts in secondary settings. They argued that while the local department remained under-staffed it should be treated by the executive social work officers as the priority area for the employment of new staff. Secondly they argued that attached posts were by definition 'specialist posts' and that this was detrimental to the development of 'generic social work' and the growth in numbers of 'generic social workers'.

Conflict in values also arose in relation to the central department's involvement in the setting up of the scheme. While the attached worker valued and appreciated the fact that her post was a 'Regional post', the senior social workers viewed the locus of control over the attachment with suspicion.

Differences in Status

The perceived privileges accorded the attached worker relative to other basic grade workers, contributed to the hostility shown toward the programme. Such attitudes in turn acted as a source of conflict within the social support system. For instance, local authority staff were aware that the attached worker could, and frequently did, bypass line management to make direct contact with executive officers. Further, it was not lost on social work staff that the attached worker was in face-to-face contact, and on first name terms, with executive officers. These were viewed as privileges generally denied other fieldwork staff. As one senior with experience of an attached secondary school post observed:

"These people (attached workers) sit in decision-making groups and discussion groups that the normal basic grade worker only reads about in letters and circulars. Another criticism that we have is that a social worker in a post like this is able to have contact with people at the top of the hierarchy. I know that from experience. To the normal basic grade worker, who has to go through channels, these people are names without faces".

The primordial role of the attached worker within the local social work department was, in contrast to the health centres, not the 'good social worker' but the 'privileged social worker'. The seniors' impression that the worker occupied a privileged position was inadvertently reinforced by the action of the executive officers. The department's representatives used the supervisor and the area team leader as their intermediaries between the central department and the area team. At no stage during the investigation were the senior officers in direct contact with area team personnel as a group. Those not directly involved in the attachment programme, therefore, felt

isolated from powerful individuals and influential decision-making bodies based in the central department.

Members of the area team were to recount other instances where favouritism was apparently shown to the worker. Although the worker had been qualified for less than eighteen months she argued that she should be upgraded to the status of senior social worker.⁽⁷⁾ Despite an absence of information about her performance as a worker, information which is generally associated in the social work literature with the assessment of the workers for promotion, an attempt was made by the senior officers to upgrade her post. Although this attempt was to fail, their support of the worker's proposal fuelled the climate of hostility between the worker, the area team and the central department.

It should be noted that the senior officers' support for this proposal was based, at least in part, on a desire to see the principle of attaching senior social workers to secondary settings established as departmental policy. Again this highlighted the fundamental structural and positional conflicts which exist between the central administration and the professionals in the field of an organisation.

Finally, area team staff were concerned that the attached worker would be ideally placed to operate her own system of priorities. They were suspicious that the attached worker would be able to 'cream off' certain types of client and certain types of problem and develop a selected caseload of 'interesting cases'.

Role Ambiguity and the Challenge to Authority

The ambiguity surrounding the role of the senior supervisor and the

relative autonomy of the attached worker also served to drive a wedge between the social work department staff and the out-posted worker. Both seniors were aware of the problems which their peers had encountered when they attempted to supervise the attached worker. The relative autonomy of the worker to work outside of the existing norms of the area team, beyond the managerial control of her supervisor, posed a threat to the power and authority of the seniors.

Similarly the active involvement of the executive officers in the setting up and operation of the programme was a source of some concern. Before the programme was implemented, one senior social worker was anxious that decisions taken at the local level could easily be overturned by senior officers. Unfortunately within weeks of making this observation area team personnel were able to cite an example of just such an episode which reinforced their fears and anxieties.

Before the worker took up her post it had been agreed with the area team that she would be based full-time in the area team for a period of one month. One week before the start of the attachment the area team leader was informed that the attached worker's time allocated in the area team was to be cut to one week although this was subsequently changed to two weeks. Area team personnel thus questioned the extent of their authority over the programme and the activities of the attached worker.

This episode again highlighted the differences in priorities between the administration and the area team. The major concern of the executive officers was, at the time, to make the programme operational. The basic grade worker, who had been the sole applicant for the post,

thought that a month's stay in the team was an unnecessary waste of her time. She then threatened to withdraw her application for the post. Faced with this threat of disruption and delay to the programme the officer felt that he had little option but to comply with her demand. Unfortunately this decision alienated the area team who wished to get to know the newcomer and wanted the worker to get to know her colleagues and the community and the resources that were available in the area.

Formal and Informal Norms of Social Interaction

The normative structure of social interaction existent within the area team interfered with the attached worker's attempts at integrating with the department. Senior staff felt that the worker should attempt to attend the weekly team and allocation meetings. The worker felt unable to make this commitment due to other pressures on her time.

Much social interaction took place between the area team workers informally over coffee and the staff room. Workers were observed to use these sessions to discuss work related issues; to exchange ideas about different types of client; and to relieve the affective tensions associated with their job. The attached worker was conspicuous by her absence from the local office.

Only negligible progress was made toward achieving a sense of mutual obligation and mutual role reciprocity between the area team social workers and their out-posted colleague. In the event, the attached worker could claim to have only limited influence within the Department. Concomitantly the area team, and particularly the senior social workers, were unable to influence her beliefs, her attitudes and her behaviour and so guarantee her conformity to the norms of the

department. The attached worker never established her professional credentials within the team.

SUMMARY

This analysis of the attached social worker's relationship with the local social work department shows the way in which the health centre situation is embedded in a wider organisational context such that the health centre participants cannot simply be viewed as locked within their work situation in a closed competition for a fixed amount of power. One could argue that the attached social worker was ideally placed to forge external alliances with her area team colleagues and superiors in order to extend her influence and power within the medical milieu particularly when she was in conflict with the doctors over the definition of the situation or a favoured course of action. In practice, however, rather than acting as an additional source of support her relationship with the social work department acted as a secondary foci of systemic conflict and inter-occupational rivalry. Firstly, during her first six months in post the worker was assigned to three different senior social workers. Thus, as she set about the task of learning her new assignment she lacked a single, definitive person to whom she was accountable and who was, in turn, accountable for her work and attended to her special needs.

Once a suitable supervisor was found a new range of problems emerged. Both the supervisor and the worker lacked clear guidelines for social interaction. One consequence of this was that managerial accountability, to whom and for what, was unclear and diffuse. This problem was in turn compounded by the involvement of executive officers

in the operation of the programme.

The attached worker tended to deny the managerial content of the supervisor's role, so the supervisor found it difficult to elicit information from the worker about her job and her work with clients. It is inferred that from the worker's point of view the supervisor had no right to instruct the worker on how to work.

The relationship between the executive officers and their professional fieldwork staff was especially problematical. Both the supervisor and the worker felt that the central administration did not provide the prerequisite support in order to achieve success in the attachment. In addition the relationships between the executive officers and the field staff was fraught with tension: the fieldwork staff and their supervisors felt professionally isolated and alienated from the central administrative process.

The social interaction between the worker and her colleagues and peers was therefore characterised by mistrust, hostility and conflict. Differences in values, attitudes, ideologies and status, were some of the sources of conflict between the worker and social work staff. In addition the formal and informal norms of social interaction which structured the group's activities acted as a barrier to social interaction and the growth of collegial support.

There was little evidence that she engaged in coalition formation activity with her colleagues outside of the health centre. Indeed her colleagues and superiors in the department were in direct competition with the health service workers for power and decision outcomes and there existed a conflict of interest between the attached social worker

and members of her occupational group. She therefore ran a constant risk of being viewed as disloyal either to one or the other of the two groups; to build an alliance with one suggested that she had rejected the other organisation and its interests.

Because of her relationship with the department the attached social worker was unable to muster the department's resources in order to employ power unobtrusively within the medical setting or to legitimise decisions which ran counter to the doctors' definition of the situation and their desire for a particular course of action. The attached social worker's access to external power resources and the uses to which these resources were put are not then simply dependent on the reactions of the parties within the medical setting.

CHAPTER EIGHT

THE PERCEPTION OF SOCIAL WORK AND THE SOCIAL WORKER'S ROLE ONE YEAR LATER

In Chapter Three I identified certain political interests and objectives which the representatives of the social work department hoped the attachment would realise. Broadly speaking they hoped that the status, influence and authority of social work would be enhanced by the attachment of social workers to secondary settings such as the health centres. The social work department's executive officers and their subordinates, the area team leader, the senior social worker and the attached social worker mutually agreed that the attached social worker would act as a role model and role sender for the health service workers and that she would assist them to acquire useable knowledge about social work thereby helping them to acquire a better understanding of social work practice. On the basis of this newly acquired knowledge the social workers also anticipated that the attachment programme would promote, amongst health centre workers, an interest in developing a collaborative and co-operative approach to service delivery with the area team based on a recognition and acceptance of social work as an equal and effective partner.

In this and the following chapter I will examine the extent to which the participants' interests were served by the attachment scheme and the extent to which each occupational group achieved its initial preferred outcomes. I begin this chapter with an examination of the participants' views of the attached social worker's role within the centre and compare these with the attached worker's definition and

perspective of her role. I then go on to look at the health service workers' views of social work and social work practice.

It is hoped that this analysis will cast additional light on the nature of power relations within the health centre setting. The achievement of the social workers' interests rested upon the attached social worker's ability to construct a definition of the situation, including her role definition, that was acceptable to her health centre colleagues. In other words, she had to act as a successful advocate of her position, convincing the participants of the criticality and centrality of her activities within their purview.

Each occupational group could, of course, argue for a different view of the social worker and her mission within the centre. In this competition, power can be derived from the ability of the actor to convince others within the setting that there are specific tasks and abilities that she has which are substantial and important to the daily operation of health centre practice.

Comparative Views of the Attached Social Worker's Role

The attached social worker performed a number of set functions common to all social work practice; assessing clients and helping to determine their needs; carrying out certain statutory duties; acting as the "gate-keeper" to material and financial resources. In addition the worker carried out a range of functions which were situationally specific and related to the health centre setting.

Sustaining Procedures

The attached worker reported that a regular feature of her role was

to offer support to patients by offering them the opportunity to discuss their difficulties with a sympathetic listener.

Ms Bishop: "I have more time available than the doctors to spend with the clients. In some cases all I've done is see the patient, or client, two or three times and listened to what they had to say. That's all I've done and that's all that's been necessary. I've put them at ease and made myself available for future sympathetic listening".

According to the social worker her supportive role also extended to meet some of the instrumental and affective needs of her colleagues. The social worker described her role as follows:

"I've also helped get impossible patients off the backs of the doctors so that they (the patients) bother me instead of the GP. It spreads the load a bit ... They've also ventilated their problems to me about their impossible patients".

All of the participants made some reference to the social worker offering patients "tea and sympathy" and "a sympathetic ear". (See figs 8.1 and 8.2). The community psychologist, for example, stated:

Mr Grant: "Also she's had a role in cases where improvements were impossible, in families where changes were simply not going to happen. There were cases where the kids or parent or parents just needed someone to talk to to express their worries and fears. The social worker gave them the support simply by being there so that patients could sound out their difficulties. That's a very important role".

However, only six of the physicians and eight of the twelve allied health workers, all but four of them based in Health Centre B, reported that collegial support had been part of their relationship with the social worker, particularly in regard to the sharing of so-called "difficult patients".

Perspectives of the Attached Social Worker's Role amongst General Practitioners (Follow-up)

Perspectives of the Attached Social Worker's Role amongst General Practitioners (Follow-up)											
Doctor	Health Centre A	Sustaining Functions	Didactic Functions	Provision of		Liaison Coordination	Supervision/		Socio-Psychological Therapy	Education	Activist/Group Worker
				Material Resources	Aid/		Social Control	Guidance Counselling			
Abel	+	+	+	+		+	+				
Baker	+	+	+	+		+					-
Craig	+	+	+	+		+	+	+		+	
Deans	+	+	+	+		+	-	-		*	-
Elder	+	+	+	+		+	+	-			
Fair	+	+	+	+		+				-	
Health Centre B											
Gold	+	+	+	+		+	+	+			
Hall	+	+	+	+		+	+	*		+	
Ivory	+	+	+	+							
Jones	+	+	+	+		+				-	-
Kelly	+	+	+	+		+	+	+			
Lamb	+	+	+	+			*			*	
McAdam	+	+	+	+							
Nelson	+	+	+	+		+	+			+	*

14	14	14	14	14	11	8	4	4	1
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+ Transactions associated with the attached social worker's role and with social work in general
* Change in positive direction
- Change in negative direction

Perspectives of the Attached Social Worker's Role amongst Attached Health Service Personnel (Follow-up)

Health Centre	Sustaining Functions	Didactic Functions	Provision of		Liaison Coordination	Supervision/		Socio-		Education	Activist Group
			Material Resources	Aid/		Social Control	Guidance Counselling	Psychological Therapy			
A											
Art (HV)	+	+	+		+	+	+				
Brown (HV)	+	+	+	+	+	+				+	
Curry (HV)	+	+	+	+	+	+	+			+	
Dollar (DN)	+	+	+	+	+	+				+	
Edge (DN)	+	+	+								
Flower (CPN)	+	+	+	+	+	+	+	+		+	
Grant (CP)	+	+	+	+	+	+	+	+		+	-
Health Centre											
B											
Henry (HV)	+	+	+		+	+	+			+	
Lite (DN)	+	+	+	+	+					+	
Miller (CPN)	+	+	+	+	+	+	+	+		+	
Norton (HV)	+	+	+	+	+	*					-
Osborn (HV)	+	+	+	+	+	*					
Park (HV)	+	+	+	+	+	*					+

+ Transactions associated with the attached social worker's role and with social work in general

* Change in positive direction

- Change in negative direction

Dr Nelson: "I think in a more general sort of way I've felt that we've had an expansion of the support team - that is an increase in the mutual support offered within the team. That seems rather abstract I know but it's very important and a very significant part of the attachment".

Dr McAdam: "I'm happy in the knowledge that there is someone else I can turn to. I know that she'll give me and my patients her support when it's required".

The 'support' to which the social worker and the health service workers referred took a number of forms; taking over the primary responsibility for the care and management of selected patients with the social worker acting as the 'key worker' for a limited although unspecified duration; sharing her colleagues' fears, anxieties and uncertainties when mutually involved in particularly difficult cases; and; less frequently, underwriting the advice given to the patient by the health centre worker.

Significantly only two of the physicians and two health visitors based in Health Centre A mentioned collegial support as a feature of their transactions with the social worker.

Didactic Action - The Social Worker as Expert

The attached worker reported that she had acted as a resource to whom patients and staff could turn for expert advice and information on matters pertaining to practical problem solving: the social worker offered practical solutions to certain delineated technical problems:

Ms Bishop: "I've helped to increase their knowledge of other agencies that can be called on so that they can do an extra bit themselves - at least - knowledge of the large range of things that are available so that they can make referrals themselves. I've provided practical knowledge about all manner of

things. Not just where to look but how to deal with agencies like housing and social security. I've helped them acquire knowledge of how to deal with these agencies".

All of the participants agreed that the worker had carried out a positive role in offering staff and patients technical advice and information:

Dr Baker: "There's been someone to whom patients can turn to find out what benefits they might be entitled to and to tell them the correct people to contact".

Dr Gold: "She has an important role giving advice ... Well I think Ms Bishop acts as an informed individual who's aware of peoples' rights etc. plus a knowledge about social security, law, and knowledge of who to see, right people to contact, - who takes decisions ..."

Dr Deans: "I suppose a second major important part (of her role) has been to act as an adviser. When one is looking for information and advice about problems in general and in particular - specifically in terms of such things as changes in the availability of allowances, it's someone who can sort out the rules governing social work and the statutory and voluntary services".

It is interesting to note when comparing the social worker's account of her role with those of the general medical practitioners, the differences in their interpretation of her role in inter-occupational transactions: the social worker perceived herself as an educationalist, someone who had educated health service workers about the structure and function of external agencies and organisations so that they too could make direct contact with them. The health service workers on the other hand viewed the social worker as someone to whom they or their patients could turn for practical solutions to concrete problems without having

to do the work themselves. The social worker therefore emphasised a role which was complementary to medicine whereas the health service workers defined the social worker's role as auxiliary to medicine.

For example, two GPs stated:

Dr Craig "She's a good reference book. She has knowledge of systems like rate and rent rebates and knowledge of the legal background".

Dr Baker: "I still see her role as a financial role for patients having their electricity turned off. She's someone to turn to in order to sort out their financial problems".

A community psychiatric nurse observed:

Mr Miller: "I see her as a sort of a data bank in the sense that, well, she could look at the case of a divorced woman and tell me, 'Well, the woman will get so much for divorcing her husband if she keeps the kids' or 'I can't get her any money but she'll get so much from social security payments or this much with rates aid, rent rebates' and so on".

Only one GP closely matched the social worker's definition of her role.

Dr Lamb: "I've learned a bit about how the law works in relation to allowances and benefits and that could help me give advice to patients in the future".

This is not to argue unconditionally that the social worker was always treated as a subordinate. Three of the doctors (Drs McAdam, Hall and Gold) described their relationship with the social worker as a partnership of equals, as the comment cited below illustrates.⁽¹⁾

Dr McAdam: "I think it's also helped to have her act as a sounding board, to act as a consultant if you like. It is someone that I know and someone who hasn't

been trained to use the medical model. It's someone who looks at things from a different angle".

I wish neither to sound cynical about the doctors' motives nor to present them as excessively Machiavellian. However, having observed them 'operate' one questioned whether or not they simply constructed a social relationship with the social worker which appeared to be based on the equality which they used to extend their influence over the worker. Secondly it can be argued that the doctors could afford to behave in a liberal manner in certain circumstances because of their potential power in relationship. In effect I am arguing that there is a dispositional aspect to power relationships in the sense that just because the power relationship was asymmetrical did not mean that the doctors always had to use it.

The Provider of Material Aid

All of the participants referred to the social worker's role in providing patients with financial and material aid. The medical staff were especially appreciative of the fact that the attached worker had: helped arrange holidays for patients on their list; arranged special payments; and had been instrumental in securing special aids and adaptations to the homes of their patients.

Liaison and Co-ordination

The social worker occupied a strategic position within the two centres linking the participants and patients with various external health and welfare systems. At the local level she relayed information between the health centres and the social work department. It was

acknowledged by all but one of the participants, Sister Edge, that the social worker acted as the Social Work Department's representative in the health centre, and vice versa. She was also known to act as an arbiter, mediator and negotiator, representing the interests of her patients to external agencies.

Dr Craig: "As a result of the attachment you know what's happening, e.g. 'This has happened or that has happened or this has happened. The police are now involved'. That sort of thing. Also she makes sure that this is paid or that is paid".

The worker occasionally carried out the delicate task of acting as the health centre's representative to the patient population and the social work department, and, on a very limited number of occasions she represented the patient to their doctor.

Ms Bishop: "I think that I've managed to maintain good relations with patients who don't have a good relationship with medical staff. Therefore I've acted as a health centre representative".

"I've reminded them (medical staff) of the characters involved and the little personal problems of the patient to help them see them (the patients) as individuals and as a whole system rather than a disease. I think that I've personalised the patients".

Only two of the general practitioners, Dr Hall and Dr Lamb, acknowledged that this had happened.

Dr Lamb: "The husband no longer trusts me as he feels that we're all ganging up on him. His wife is still registered as one of my patients and comes in to see me quite regularly. But the husband has paranoid ideas about us which he expresses to Miss Bishop. She's one of the few people he trusts".

The Statutory Role of the Attached Worker

Three of the physicians (Drs Ivory, Lamb and McAdam), and two of the district nurses (Sister Edge and Lite) made no mention of the social worker's statutory duties. The remaining participants again referred most often to the social worker's supervisory role in cases of non-accidental injury to children. In addition, two of the physicians referred to the social worker providing after-care to ex-offenders.

At the very least the medical and allied personnel were aware of the range if not the substance of the attached worker's instrumental tasks and activities. However when we turn to the less tangible aspects of the worker's role, those aspects which had to do with the affective-expressive component of social worker practice, with the social worker acting as counsellor and therapist to the patient, a different picture begins to emerge.

The Social Worker as Counsellor

The social worker reported that she had acted as counsellor, offering information, advice and guidance to selected groups of patients, e.g. counselling single, unmarried pregnant women about the options available to them; describing the problems and prospects of single parenthood; and helping them to plan their future course of action. In addition the social worker reported that she had participated in marriage guidance counselling and the counselling of patients with problems related to the abuse of alcohol.

Fourteen of the participants referred to the social worker's counselling role. The community psychologist observed, as she had done

at the first interview:

"The social worker has the necessary skills and expertise to act as counsellor. She observes the relationship between mother and child or between the child and parents and between the parents. From there she works out what the basic problem is and the best approach to take and then counsels them on either alternative ways of behaving or the adjustment they'll have to make in relation to one another or whatever".

The other staff members who mentioned the worker's counselling role tended to think in more specific terms. For example, a GP/Gynaecologist commented:

Dr Abel: "She's also helped in counselling at least as far as the single girl who is pregnant is concerned - Going through the alternatives to abortion, like adoption, and what would happen if they continued the pregnancy and so on".

Another physician said:

Dr Lamb: "A couple that I've referred have been helped by Jane. She's been available to discuss their relationship problem to help them see the problem from the other person's, the other partner's point of view. Also she's helped to explain why the partner doesn't conform to the way they want them to behave, to their ideal behaviour. Really I mean counselling, marital counselling, with the individual and family. I hadn't considered that as part of the social worker's role before".

Fifty per cent of the respondents made no mention of the worker's counselling role within the primary care team. Indeed the idea had never occurred to many of the respondents who expressed surprise when they were informed that the social worker had described her role in this way. For others the idea of the social worker acting as a counsellor to patients had been considered, but, in the final analysis, rejected:

Dr Deans:

"I'm not sure how to put this. I think she's been able to give appropriate advice to people with problems of basic items for living. Housing advice, advice on sheltered accommodation, that sort of thing. I think in material ways she's proved very valuable. I think my perception of her role is less sure in terms of her effectiveness when it comes to counselling or the modification of behaviour. I'm just not convinced. I don't know how much experience they have in their set-up to do this sort of thing".

This illustrates the way in which the doctor's ideas about the social role of the attached social worker can shift over time. While at one stage he may support the social worker counselling patients his ideas could quickly change to that of denial that this is a legitimate part of social work practice. This shift is the result of the doctor's accumulation of bits of information, situational practice factors and prejudice. In this case the respondent was one of the doctors who failed to get into a relationship with the social worker and subsequently sanctioned her by only referring patients with practical concrete problems. The doctor's 'doubts' about the social worker's ability to perform a counselling function were not, it should be emphasised, based on direct observational experience of watching her at work. Nor was he able to tap alternative sources of information which would cast some light on the social worker's practice skills other than what he may have learned from the patient.

The doctor's account illustrates an attempt to explain what was substantively a political decision as a matter of 'rational choice and decision making' related to the quality of the social worker's practice: the social worker's apparent 'failure' to perform to the satisfaction of the doctor in one sphere of activity and as team member, e.g. by responding to his 'request' that she attend meetings and provide him

with the information he required, was sanctioned by the doctor applying coercive pressure on the social worker in another sphere of activity, her role as practitioner.

The Social Worker as Therapist

A major contested area of practice is psycho-therapeutic work with patients suffering from a wide range of psychological and emotional problems.

The attached worker acted as the co-therapist of a physician, Dr Kelly, at the Sexual Dysfunction Clinic, and had an active interest in both child and family psychiatry and the counselling of problem drinkers. On the basis of their response to both open-ended and focussed questions about the social worker's therapeutic role the participants could be placed into one of four groups:

(i) Those who were familiar with the attached worker's therapeutic activities (Drs Hall, Gold, Kelly, Sister Flower, Mr Miller and Ms Grant). It is noteworthy that all but one of the respondents in this group provided psycho-therapeutic services within the centre and/or the local psychiatric hospital;

(ii) Those who were aware of the worker's therapeutic encounters with patients but were unaware of the substance and form of her intervention (Drs Ivory and Art, and Nurse Park);

The second group of participants, as a result of their position in the organisation structure, knew of the social worker's close ties with certain physicians and theorised that the social worker's repertoire of activities extended into the field of psycho-social work.

Dr Ivory: "She's tied up with Dr Kelly in the Sexual Dysfunction Clinic. I know that. I only learned about her involvement recently when I glanced through the (referral) letters at the back of the patient's records. I would have had no idea otherwise".

Nurse Park: "Because I work with Dr Kelly I see her dealing with psychiatric problems and certain marital problems. I know that she's involved but please don't ask me to explain what she does".

When pressed to explain, the health visitor reported that she saw the worker's involvement in psycho-therapeutic work in instrumental rather than therapeutic terms: she commented that the social worker either arranged child minders or nursery places for children in order to relieve their emotionally disturbed parents of various social pressures; and, that she gave this type of patient legal advice and information on benefits and allowances. The fact that staff members were aware of the specialised context within which the social worker operated was not sufficient in itself to guarantee that they knew, understood and accepted the worker's contribution to the therapeutic process.

(iii) Thirdly, there were those who were aware of the social worker's interest in therapy but rejected her claim to expertise.

(iv) Finally there were the majority who were unaware of the social worker's participation in the Sexual Dysfunction Clinic and her interest in therapeutic work. When informed of the social worker's involvement with the psychiatric team this group of respondents expressed real or mock surprise.

Dr Baker: "That comes as a surprise. I wouldn't have thought that the social worker had a lot to contribute to the community psychiatric team. Unless the

individual social worker had specialist knowledge and some training in psychiatry and psychology".

The Social Worker as Educator

Another of the most important and daunting roles prescribed for the social worker was that of educator. According to the attached worker she was engaged in a continuous process of 'educating' all of the participants about her role in the primary care team and the role, principles and practice of social work and social workers.

"The other bit (of my role) is education, to increase the medical personnel's knowledge of social work and the skills that social workers use to alleviate problems. Also I tell them about the role that social work might have to play and our different ways of working".

She argued that the intuitive common sense understanding that the participants had of social work and social work practice at the start of the attachment scheme, was replaced by a harder, more substantive, appreciation of social work which was at once more precise, accurate and positive. Further, she reported that in some cases she had helped reshape the GPs perception and understanding of the patient.

Ms Bishop: "The GPs do discuss cases with me a lot in a conversational way. It's a two way thing. By getting my opinion I think it does affect the way the GP reacts to the patient".

Finally, on a more pragmatic level, the attached worker reported that she had helped the participants attain a better understanding of social welfare legislation;

"I think that I've helped them to understand more about the limitations of the law and the facilities

that are available to both social workers and their patients, or clients"

The health service workers were far from unequivocal when it came to assessing what they had learned from the social worker during her first year of practice. A common response when, for example, they were asked to describe the social worker's contribution to the care and treatment of patients experiencing relationship difficulties and patients suffering from problems of mental ill health was that of the GP who said:

Dr Jones: "I don't think that I'd like to comment on what her work has been. Really I'd rather hear more about that from the social worker. She should define what her role is, has been, or should be. It would have been useful if she had said 'I can allocate some of my time to this or that. What do you think'?"

In only one or two cases did the attached worker achieve a certain measure of success by injecting a new realism into the expectations that the participants had of the ability of social workers to make provision for material and financial aid. In so doing they became more aware of the pressures and limitations that social workers faced when trying to secure resources for their clients.

Dr Deans: "I've learned a little about social services availability and a bit about the operational difficulties they face - i.e. manpower, rules and regulations".

In general, the participants were no more advanced in their understanding of the organisational and administrative structure of the social work department than they had been at the start of the programme. While the department's use of a priority list for the allocation of

cases no longer generated the frustration that it had done the previous year, it remained a mystery in terms of its content and function. Likewise the department's change from a patch system of service delivery to one which was based on long term and short term teams was still not understood.

Social work places great emphasis on what may be defined as the value component of practice. According to much of the literature social work practitioners are inculcated, during the course of their training, not simply with knowledge and skills, but appropriate professional values and attitudes.⁽²⁾ Again, only three of the participants (Drs Hall, Baker and Lamb) made some reference to one or more of the elementary values said to be central to social work practice, i.e. the high priority placed by social workers on the value of the individual to direct his or her own life (self-determination) relatively free from external control.

The data from both the follow-up interviews and informal discussions with the participants indicated that only two respondents, Nurse Osborn and Dr Hall, had advanced their understanding of social work values. Having contacted a social worker in the nearby area team the health visitor commented:

"The advice I got from him was to let, to tell the woman to get in touch with the local DHSS herself. Which I suppose was the kind of ideal thing for her to do. I guess he was right really. - Because, ah, it's better that she did something for herself rather than have one of us do it for her".

Only one practitioner, Dr Hall, made a significant breakthrough in his knowledge and understanding of the wide spectrum of values

associated with social work practice. In his discussion of social work practice the physician systematically referred to the central values of social work:

"They, social workers, can help a lot of the patients. I'd say in terms of problems which are of a social rather than medical nature. They help by allowing people to make decisions about their own future. (My emphasis)"

"I've been impressed by their non-judgmental approach to patients with problems. It allows for a completely fresh approach to problems. I do have a better understanding of their capabilities now. And the range of their work and the more theoretical aspects. - I must say however, that it's hard for me to separate what I've learned from the attachment from my other contacts with a range of social workers on the adoption panel". (My emphasis).

The majority of the participants demonstrated neither a coherent nor a comprehensive understanding of the professional values of either the attached worker or social workers in general. It may not be coincidental that the two respondents who had made obvious gains felt obliged to draw the researcher's attention to the fact that any change in their knowledge about social work could not be attributed solely to the attachment programme. The two participants reported that they had learned a good deal about social work practice through their contact with social workers in other settings, e.g. on adoption panels, in hospital.

The majority of the participants expressed the view that the attachment had done little to expand their knowledge of the social worker's role and of social work generally. As one GP observed:

Dr Elder: "I don't feel that the attachment has advanced my understanding of the underlying premises of social work and social work practice. And I wouldn't say that I've learned much about the skills, or the role if you like, of the attached social worker or social workers in general".

Dr Fair: "Maybe I should clarify what I've learned from the attachment. I'd summarise by saying that I've learned very little about social work in general. And I couldn't identify any one area where I've gained new knowledge about the field from Jane's attachment here".

Social Worker as Activist

The social worker also pursued a number of interests in arenas outside of the health centres. The attached worker made a direct contribution to the resources of the area team by participating in the identification, assessment and selection of potential foster parents. Later in the year she collaborated with a social work department colleague to organise an educational and recreational programme for a select group of mothers and their toddlers drawn from the catchment area.

Only one member of staff, a health visitor, reported that they had been informed of the social worker's group work activities. Similarly only the physician who was a member of a voluntary committee mentioned the social worker's work in the voluntary sector.

Clerical and Administrative Duties

Like her counterparts in the local authority department the attached worker had a number of clerical and administrative duties to perform, including the writing of case notes; social enquiry reports and correspondence. In addition she was expected to perform a number of

role specific functions: she organised and chaired the monthly social work--health centre meetings; attended, on an irregular basis, monthly health centre management meetings, and contributed to the documentation in medical records.

All of the participants had direct experience of the social worker attending to some, but not all, of her administrative and clerical tasks. The participants were unaware of the wide range, and time consuming nature, of these demands. In addition a significant minority of the participants were critical of the social worker's administrative performance, particularly in regard to her role as chair person and her apparent failure to contribute to the medical records on a regular basis.

Knowledge and Perception of Social Work Practice

As might be deduced from the findings presented above, results from the follow-up interviews with the participants revealed few marked changes in their knowledge of social work transactions. (See Figs. 8.3 and 8.4). Twelve of the fourteen physicians referred to the same, or similar, types of social work transactions in the follow up interviews as they had a year earlier.

Of the two physicians whose response to the interview suggested some degree of change; one of the physicians no longer considered guidance, counselling and individual/family therapy as a legitimate part of social work practice. When questioned about this change in perspective the GP replied:

Dr Elder: "I can no longer support the social worker's involvement in cases which require this type of

FIGURE 8.3

GP Knowledge of Social Work Practice (Follow-up)

Doctor	Sustaining Functions	Didactic Functions	Provision of Material Resources	Liaison Coordination	Supervision/Social Control	Guidance Counselling	Socio-Psychological Therapy
Health Centre A							
Abel	+	+	+	+	+	+	
Baker	+	+	+	*	+		
Craig	+	+	+	+	+	+	+
Deans	+	+	+	+	+	+	+
Elder	+	+	+	+	+	-	-
Fair	+	+	+	+	+		
Health Centre B							
Gold	+	+	+	+	+	+	+
Hall	+	+	+	+	+	+	
Ivory	+	+	+	+			
Jones	+	+	+	+			
Kelly	+	+	+	+	+	+	+
Lamb	+	+	+	+		*	
McAdam	+	+	+	+			
Nelson	+	+	+	+	+	+	
Total	14	14	14	14	10	8	4

* Denotes change in knowledge of positive direction

- Denotes change in knowledge of negative direction

FIGURE 8.4

Health Centre Workers' Knowledge of Social Work Practice (Follow-up)

Health Centre	Sustaining Functions	Didactic Functions	Provision of Material Aid/Resources	Liaison Coordination	Supervision/Social Control	Guidance Counselling	Socio-Psychological Therapy
A							
Art (HV)	+	+	+	+	+	+	
Brown (HV)	+	+	+	+			
Curry (HV)	+	+	+	+	+	+	
Dollar (DN)	+	+	+	+	+		
Edge (DN)	+	+	+				
Flower (CPN)	+	+	+	+	+	+	+
Grant (CP)	+	+	+	+	+	+	+
Health Centre							
B							
King (HV)	+	+	+	+	+		
Osborn (HV)	+	+	+	+	*		
Park (HV)	+	+	+	+	*		
Lite (DN)	+	+	+	+			
Miller (CPN)	+	+	+	+	+	+	+
Norton (HV)	+	+	+	+	*		
Total	13	13	13	12	11	5	3

*Denotes change in knowledge positive direction

involvement. I'd say that social workers have limited expertise and training and ability in psychology and psychiatry. Particularly in terms of theory. Which isn't to say that I have a great deal of expertise in psychological theory. But we have someone who is. Mrs Grant the attached clinical psychologist".

Similar results were obtained from the attached health service workers. Only four of the participants, all of them health visitors, could be identified from the data as having developed a more comprehensive understanding of social work transactions. The three newly qualified health visitors referred to those social work transactions which included a supervisory, or social control, element to practice.

Medical Dominance, Social Work and the Division of Labour

A number of interesting findings emerged from the follow up interviews with the participants which focussed on their perception of the social worker's role in the medical division of labour.

The participants were aware of the social worker's instrumental tasks and activities. In their view the social worker had a legitimate and proper role to perform in relation to: the provision of material and financial aid to the patient; liaising with external agencies on behalf of patients or their health centre carers; providing patients and staff with advice and information and; offering support to patients and professional workers.

The difficulty that the majority of the participants originally had of apprehending the nature of the social worker's sustaining procedures, persisted. The worker's ability to offer her support to emotionally

distraught patients was thought to be based on common sense and a product of the time she could make available to the patients rather than as part of a complex process of assessment and the selection of an appropriate strategy of intervention amongst a range of techniques. The participants continued to 'de-skill' at least one key aspect of the social worker's role within the primary care team.

Dr Elder: "Support? In an ephemeral way. I mean regular discussion which is supportive. And the social worker's involvement in the basic difficulties of the family, which are usually financial - It isn't so much of a skill, or her particular skills, as the latitude of the job. The social worker has the time to be involved".

Dr Fair: "Surely she's had a supportive role in dealing with people and families in coping with their social situation. It's simply what we (physicians) do in practical terms. Listening, talking and reassuring the patient. But mainly listening".

In the main, the social worker failed to persuade the doctors and his para-medical staff that her role was more sophisticated than they had originally believed.

In addition the social worker's sustaining role within the centres tended to either reflect or reinforce the existing power structure. Although the social worker defined her role as complementary to that of the doctors in some instances, her actions were that of an auxiliary to medicine; 'saving the doctor's time' and 'doing things that he does not have the time to do'. In short, the social worker cast herself into a subservient role to the doctor, and defined her role in relation to the doctor.

There are a number of explanations which might account for the

social worker's behaviour. Freidson might argue that the social worker's attitude and behaviour toward the GP represents the behaviour and beliefs of a member of a subordinate occupation who, once he or she had become a part of the hierarchical authority structure in the medical setting, built his or her work around the interests and needs of the doctor and fitted into the established norms of inferiority. On another level Huntington might say that the attached social worker's attitude and behaviour were those of a subordinated female social worker acting out the traditionally subservient role of women in relation to the dominant male medical practitioner.

Another way of looking at the power relationship between social work and medicine would be put forward by Strauss and his colleagues (1964) who might say that the social worker's behaviour represent the outcomes of a negotiative process between two equals: that her behaviour was nothing more than what one would expect in the give and take of practice within the medical setting.

This third explanation would have found some favour with the participants who maintained that they treated the social worker as an equal but that the social worker had failed to 'act' as an equal.

They expected the social worker to take an active participatory role in both the monthly social work—health centre meetings and the Health Centre Management Committee meetings. In addition the worker was encouraged to attend and participate in the regularly scheduled practice and clinical meetings and to use such meetings as a vehicle for disseminating information on topics relevant to social work in the health centre and the attachment programme. Unfortunately the social

worker rarely attended these meetings, much less acted as the key speaker or organiser of a programme. It was with a sense of regret that some of the participants observed:

Dr Deans: "She never came to us with any specific proposals about areas that we should be looking at together. There have been enough opportunities to express her views about issues which she's interested in. We haven't discussed broad social issues. That's unfortunate. Surely that's a part of her role".

The doctor added:

"I'd like to have seen Miss Bishop more aggressive in her approach toward us. She could have told us more about the contribution she had to make to the primary care team. She's taken a passive role, I know that sounds unfair and it probably reflects the aggressive role we take. We are experimental, and we do have an innovative approach to patient care. One would have liked to see the social worker adopt the same type of attitude. We don't think you can become part of the team unless the person concerned is prepared to be assertive. I'd say that the attachment hasn't been so successful but the service has been O.K."

A health visitor commented:

Nurse Curry: "I'd have welcomed the social worker making a contribution to the team by explaining her role. I don't know what she's able to do or what social workers are able to do. She could have explained her role, her abilities and her contribution".

The notion of a company of equals, negotiating and bargaining the terms of their work, is weakened however, because at no stage in the attachment programme were the doctors observed either to define their role or act as an 'auxiliary' to a para-medical occupation in the way that para-medical and lay workers defined their role as subservient to and an auxiliary of the doctor. In addition, it was by no means clear

that when faced with dissent over an issue of key importance to the doctors, that they they would have willingly altered their behaviour, either thought or action.

What these various theoretical approaches fail to take into account, because they focus either upon formal authority or see power as equally distributed in the setting, is the coercive element in the social work--medicine relationship and its impact upon the division of labour within the health centre setting. The social worker was conscious, particularly at the start of the attachment programme, that her superiors in the social work department looked to her to make the attachment programme a success in the eyes of the participants. This pressure on the social worker made her willing to act, on occasion, as the auxiliary of the doctor in order to win their approval in the hope that they would judge the programme a success.

There were a number of factors which appeared to influence the GPs' and the other participants' perspectives of the social worker's place within the division of labour within the medical setting.

The Case Dominated Approach to the Socialisation of Health Centre Participants

I argued in the previous chapter that the social worker was more comfortable dealing with individual clients than she was thinking about and dealing with the organisation in which she worked. This preference was also seen in the way she set out to change the participant's knowledge of and attitude toward her role and the role of social workers. She chose to use a case-oriented, or case-dominated approach to socialise the participants into acceptable patterns of thought and

action. That is, she used the referral of individual patients as a basis for explaining her role, and the nature and principles of her practice. This approach had a number of inherent limitations.

Firstly, the social worker's broad range of activities, her interests and her expertise, were not made apparent to the participants. As one GP observed:

Dr Fair: "The main drawback this year was that the referrals were quiet and unobtrusive. You got the feeling that something was going on but you didn't know much about it".

As a result the participants were never exposed to the full range of her activities. Indeed, the process tended to reinforce the rather narrow definition of the attached social worker's role held by some of the participants at the start of the programme.

The participants tended to refer patients with particular types of problem which in a general way matched their expectations and understanding of the role and skills of the worker. Those participants who thought of the social worker's role in material and instrumental terms tended to refer patients with practical problems. The social worker's subsequent action in response to the referral then acted to reinforce their original conception of her role as, for example, the "Miss Fix-it" of practical problems.

Dr Jones: "Well, I see her as 'little Miss Fix-it' really, I must clarify what I mean by that. I know she negotiated with old folks' homes for people who were in need of short term care, holidays, things like that. At least that's what I've used her for".

Nurse Brown: "The only thing that I've learned about social work is the fact that social workers should know about legal things. The rules and regulations. I know vaguely what they do and what Jane does but I still couldn't say what is or what isn't their contribution to the care of the individual".

The organisation of the centres also imposed constraints on the social worker which made this individualistic model of professional socialisation problematical, as one GP observed:

Dr Abel: "The several times that I've referred problems there has been no, or only slight, informal response to what's happened or else it's been a brief chance meeting when we haven't had the opportunity of going into the case in any great detail".

In these brief medicine--social work encounters, attention is focussed upon the transfer of concrete factual information between the worker and the referral agent. Higher order questions related to the philosophical and epistemological underpinnings of her practice; social welfare legislation and its impact on social work; and the factors affecting the social organisation of the local community were never addressed despite the expressed interest of some of the participants to discuss such issues⁽³⁾.

Dr Deans: "I'd have liked to have had the opportunity to discuss with the social worker broad social issues - like the factors which social workers see influencing the infrastructure of the New Town and more philosophical issues related to social work. It's the whole interchange of ideas between professions that unfortunately hasn't happened".

Ms Grant: "We don't seem to have dealt with the broader things which I feel we should have discussed. - Policy issues like housing and re-housing and the priorities of social workers. I don't know if they have new priority areas now that they have more people working up there. - Policy and philosophical

issues surrounding children at risk and NAI cases. And what the common ground is between their work and our work. We haven't dealt with these broader questions".

Another central weakness of this type of approach to 'educating' the participants about the tasks, functions, activities and beliefs of social work is that it relied on the social worker providing her colleagues with a continuous stream of information about the social worker--patient relationship. As I have shown elsewhere, in an attempt to control another aspect of work, her workload, the social worker chose to disengage from medical personnel in the centres and restrict the amount and type of information she provided them with about her work with clients.

Dr Fair: "I think that at times it's apparent and unfortunate that doctors do have very obvious limitations. The fact that the relevant person isn't able to come to meetings because of time and other commitments is a great pity. We were told, through a letter, that she had too much to do and that she wouldn't be able to come. From an educational point of view I've gained very little".

Dr Elder: "From an academic point of view, because of her lack of involvement with the primary care team some feel that we have not advanced our understanding of the basic social work premises and what skills the social workers have".

The feedback of information about her work with individual patients to the referral agent was, by the worker's own admission, given low priority, downgraded and marginalised. It was not surprising that the participants made such comments as:

Dr Fair: "I think my answers (regarding the attached worker's role) are coloured by the lack of communication and feedback from the worker. It's continuing ignorance on my part. The times that

I've referred problems there has been no, or only slight, informed response to what's happened".

Dr Baker: "I'd like to have had more feedback from the social worker - to explain how she saw her role within the health centre set-up and to tell us if we're referring the appropriate cases. Also, I'd like to know more about how much she was able to act on these cases and what results she had achieved".

Unlike the findings reported in earlier empirical studies of attachment schemes (Gilchrist, et al, 1983) the attached worker did not lack the opportunity to engage the participants in discussion and debate. The participants offered the attached social worker their time and, what is more, appropriate venues for the discussion of issues of mutual interest and the dissemination of information about her practice and the practice of her social work colleagues. Such opportunities for inter-occupational contact and collaboration were sacrificed as a means of adjusting her workload: her non-attendance at meetings formed part of her overall strategy for dealing with the demands made upon her time by both patients and professional workers.

Similarly, while the local authority social workers were provided with the opportunity to systematically explore and discuss social work theory and practice at the monthly social work--health centre meetings, such opportunities were rarely exploited. This is particularly surprising considering the fact that as the attached social worker organised and chaired the monthly health centre--social worker meetings they were in a particularly advantageous position to control the agenda. That is, they were in a position to define what was an issue or potential issue for discussion with the doctors in order to promote their interests (Lukes, 1977).

Social Work as Problematic

Dr Kelly: "They (social workers) seem to fear people knowing what they're doing and what their limitations are. I've assumed that they have certain abilities but it doesn't come through to me. I've assumed that she could have extended into family and marital therapy".

Dr Fair: "A general criticism of GPs is that our ideas about social work are distorted. Or that we're misguided about what a social worker can or should do. They could educate us regarding their practice and their work. I'm sure that the social workers have misconceptions of our role and our work and how we deal with patients. But they don't appear, at least to me, to want to discuss these issues".

Many of the participants held the opinion that both the attached worker and her local authority colleagues purposefully avoided entering into a discussion about social work; that they feared placing social work into the arena as a central topic for debate.⁽⁴⁾

Dr Elder: "They don't seem to have the ability to be forthright about their work, their values and other similar issues. So what I'm saying is that they appear to be blinding us and themselves, for convenience and minimalising their skills".

Mr Miller: "They seem to fear people knowing what they are doing, why they're doing it and what their limitations are. So I assume that they have certain abilities and skills based on their background and experience but it really doesn't come through to me".

The apparent evasiveness of social workers was itself a source of inter-occupational mistrust. This led the community psychiatric nurse to offer the warning that:

"The longer they try and put off putting up a sign for business, which obviously you have to make understandable to anyone who isn't a social worker.

That's common sense, the more misconceptions other agencies have about social work the more people will become dogmatic. In the end people will do it for them. They'll put a definition on them. 'Right, you do financial problems'."

In a recent review of social work practice Martin Davies, Professor of Social Work at the University of East Anglia, comments:

Social work's angst has recently resulted in its representatives and teachers devoting long hours to a search for definitions in an attempt to persuade themselves of their profession's legitimacy ... (Davies, 1981, p.13)

This search culminated, according to Davies, in the publication by the British Association of Social Workers, of The Social Work Task (1971). The title, writes Davies, is misleading as social work lacks the functional specificity implied by the title:

For there is no such thing as the social work task; it is not even certain that there is any such activity as social work, in the sense that nursing, teaching and hairdressing, for example, are self-explanatory terms. (Davies, p.3)

This view of the contemporary state of social work would have struck a sympathetic chord with some of the participants, one of whom commented:

Mr Miller: "Social work means nothing to me. At the moment it's difficult to know when to ask for their help. The term 'social work' is too broad to be meaningful to me".

Given the state of conceptual ambiguity which surrounds social work it is perhaps unremarkable that the social workers withdrew from direct contact with health service staff and did not enter into open contests

with the doctors over the definition of social work. In the course of observing the monthly meetings it did seem that the social workers were unable to articulate, express and maintain what could be called a social work perspective. Following Bucher (1970) it seems to me that inter-occupational politics and the use of power within the health centre setting, processes which involve argumentation, presentation and debate, the ability to articulate a position is essential for the actor to be successful in his contestations with others. In the absence of the necessary resources to engage in contests at this level, a cogent and coherent conceptual frame of reference which adequately identifies and describes social work practice, fieldworkers might well have been fearful of entering the arena where social work and the nature of the social worker's role is the primary topic for debate.

SUMMARY

Direct observation of the participants in interaction and follow-up interviews with the respondents twelve months after the start of the attachment programme revealed few marked changes in their perception and definition of the attached social worker's role. Fifteen of the twenty-six participants (58%) were to all intents and purposes unaffected by the attachment and maintained similar perspectives of her role to those they had at the start of the programme. The interviews revealed a number of important differences between the attached worker's account of her role and the definition(s) of her role held by health service workers.

The participants agreed with the social worker that she had performed a range of valuable practical, instrumental, functions, e.g.

making provision for material and financial aid to patients, acting as a source of concrete information and problem-solving advice, linking the health centre with outside agencies and institutions. Indeed for a large proportion of the respondents, this was her role. In part their perspective was conditioned by the social worker's own behaviour. From the start of the attachment programme the social worker fell into line with the normative expectations for her role within the centres and catered to the practitioners' demand for practical help. Although her behaviour may be explained as the response of a subordinated worker to the hierarchy of medical authority, I have argued that the threat of the doctor's applying negative sanctions also played an important role in determining the eventual outcomes of the social worker's decisions. The social worker was anxious, at least in the early days of the attachment, that the participants judge the attachment a success. She therefore went out of her way to accommodate their desire for a social worker who took practical steps to resolve their patients' concrete problems - in so doing reinforcing their prejudicial view of the social work role - in the hope of winning their approval of the scheme.

The preferred outcome of the attachment, from the point of view of the social workers, of educating members of the primary care team about the social work role, and the values, principles and practice organisation of social work was, by and large, unmet. Generally speaking the health service workers remained unable or unwilling to distinguish social work from other forms of social service work. The majority of the participants also remained unaware of the range of transactions that can, and do, occur in the social work--patient relationship, the values which are purported to inform their practice,

and the factors which shape the organisational structure of the social work department.

How can we account for the apparent failure of the attached social worker and her area team colleagues to successfully persuade the health centre participants to adopt a social work frame of reference and definition of the social work role?

Firstly, the strategy used by the attached social worker to control her workload and avoid assessment was to keep secret the information necessary for evaluating her decisions and activities: she only released information with various indicators of inputs e.g. how many referrals she had received and where they originated from, and kept back information about processes and outcomes. Given that she tended to use individual referrals as a means of persuading the participants to change their views about social work within and outside medicine and to educate them about the range and substance of social work practice, the impact of her work control strategy is obvious. The decision by the social worker to limit her contact with health service workers, and to restrict the information she passed on about her practice, meant that while she was 'protected' from the demands made of her by the doctor, she lost opportunities to convince them of her technical and theoretical sophistication and skill as a practitioner.

Secondly, the results from the study also suggest that the social workers were unable to articulate a social work perspective and maintain a social work position when they encountered doctors and other health workers whose definition of the situation differed markedly from their own.

In order to be a successful advocate of one's position and to successfully construct an acceptable definition of the situation when in contestation with others requires both verbal skills, articulateness, and the ability to present a clear and coherent argument. This presupposes that the protagonists each have a position from which to argue their point. It seems that social work is at a disadvantage to medicine because it lacks what could be defined as a social work position of its role and its function within the health and welfare system. That is, if influence is realised in everyday settings through a process of interaction and negotiation the social workers come to these interactions lacking an essential resource.

CHAPTER NINE

ACHIEVING PREFERRED OUTCOMES: SOCIAL WORK AND MEDICINE COMPARED

The third item on the social workers' political agenda was to foster collaboration and co-operation between the health and welfare services, at the very least, at the local level of service delivery. Although I have given some indication of the state of play in this relationship in previous chapters, in this chapter I will give a brief description of the attitudes of the participants toward the local social work department and their response to inter-occupational work one year after the start of the attachment. I will then go on to consider the health centre participants' views of the attachment and the extent to which they achieved their initial preferred outcomes.

Results

According to the attached worker, her senior supervisor and the area team leader, some measure of success had been achieved in bringing about the hoped-for changes in the working relationships between the participants and the social work department.

Mr Carson: "I think that because of the attachment there is better liaison with the health centres. It's encouraged contact between this department and the health centres through the monthly meetings. In some ways a contact point has been made and now contact is much easier".

Mrs Argent: "It's certainly stabilised our relationship with the health centres and improved it. We don't seem to have as many hassles with them now as we did before".

Certainly it was possible to detect a change in the organisational

climate in the centres toward the area team. The almost palpable atmosphere of tension and hostility which had at one time characterised the relations between the two agencies had diminished. It is also of no little significance that during the investigation the participants' criticism of the department's use of a 'team approach' to service delivery and its use of a 'priority' system to allocate work declined in terms of both the frequency and vehemence with which it was at one time discussed. This change can be attributed to a number of factors. Firstly, as I demonstrated in the previous chapter, there was an increased appreciation on the part of some of the participants of the problems and pressures facing the resource-dependent social worker.

Additionally, during the year the social work department staffing levels returned to establishment strength, and it was, therefore, better able to respond to new referrals. Thus, two physicians felt able to report:

Dr Hall: "I think the relationship of the doctors with the social workers and the social work department has improved - it's much easier and more relaxed. It's a more amicable relationship".

Dr Elder: "There's been some improvement in liaison with the social work department and some increase in a cohesive and coherent approach to patient care. There's a little more understanding of a combined approach toward a particular patient or his or her family".

Such improvements were, however, far from universally reported. Eleven of the physicians reported no overall improvement in the health centre--social work relationship, an opinion which was echoed by the allied para-medical staff. The majority of the participants remained highly critical of social workers and the organisation of the

department.

The majority of the participants continued to identify three elements in the administrative structure of the area team and their relationship with social workers which contributed to an overall sense of dissatisfaction with the department. Firstly, the resistance of social workers to define their role. This has been discussed in the previous two chapters. Secondly, the perceived reluctance of social workers to exchange information with the health centre participants about patients and their problems. Finally, administrative delays associated with the process of case allocation continued to act as a barrier to inter-occupational work and communication.

Communication Problems

The hoped-for improvements to the pattern, frequency and content of the information which flowed between the health centre and the social work department did not, according to all but three of the GPs, (Drs Abel, Elder and Hall) materialise. On the positive effect of the attachment one GP commented:

Dr Abel: "Things have improved. Now they put me in the picture. At least they did in relation to one case. - Come to think of it, I did have to ask them for the appropriate confirmation in writing".

This more positive perception of the relations between social workers and medical and para-medical staff was atypical; the majority of the participants could discern no such improvement in their relations with area team personnel.

Dr Fair: "The way I'd describe the contact is vague. You have the feeling that once a problem has been

brought to the attention of the social work department, you don't hear anything else about it. Really, basically it's a lack of communication. You refer an active (on-going) difficult problem and there's no reply. There's no fresh communication. So I generally find that I'm left in the dark".

Nurse Art: "What we're still looking for is good reliable information about our patients that they're dealing with and we're not getting it. As far as I'm concerned the information is still one way".

They were, in addition, critical of the fact that in order to acquire information about the patient they were obliged to seek it out. The two respondents went on to state:

Dr Fair: "Unless I continue to follow them up the social workers aren't forthcoming with what they know".

Nurse Art: "If you want information you will have to ask for it. And even then there's no guarantee that you'll get it".

The necessity of having to seek out information from the social workers, rather than their passing it on to health service workers as a matter of routine, continued to rankle with many of the doctors and para-medical workers. These and other comments suggest that the health service workers regarded the social workers' lack of response as a 'slap in the face', a challenge to their competent and legitimate authority.

The participants also remarked that when information was forthcoming it still tended to come in a highly edited form. A community nurse observed:

Sister Flower: "When you do ask for information you get enough to satisfy the basic questions and no more. At one time I wasn't really sure of that. That they held back information. But I certainly do now.

When I ask Jane there's always a bit more detail. She fills some of the gaps - yes, I'm critical. Their reply to the questions I've asked is either 'Oh well he's doing fine' or 'I don't know, someone else is working on the case' or 'I don't feel that there's a need for further action'. End of story. You get the bare essentials. - You can try and get more information but it's difficult if not impossible. It's better going to Jane. At least you get a bit more detail".

The perceived reluctance of social workers to share what they knew with the participants was interpreted as nothing less than an obvious example of their professional hauteur.

From the social workers' viewpoint, however, to divulge all that is known about the client and his or her circumstances might have been regarded as an unwarranted intrusion into the private life of the client. Second, it is at least arguable that the social worker had, in certain cases, acceded to a client's wish that certain pieces of information remain confidential: to have broken their agreement would have meant that the social worker had broken their 'contract' with the client. Third, had the social worker just become involved in the case they may have wished to remain 'neutral' until they had arrived at their own assessment of the client and the nature of his presenting problem.

Defensive Medicine: Defensive Social Work

Cultural conflicts arose in other areas of the social work--medicine relationship. It is alleged that social workers and medical practitioners engage in manoeuvres which are designed to protect the practitioners from outside criticism and litigation should their judgment and behaviour be questioned. (Hershey, 1972; Mechanic, 1978; Hoghugh, 1979; Davies, 1981). It is argued that practitioners will in

certain circumstances or in relation to certain types of cases adopt a defensive posture by doing more than is necessary in order to protect themselves, particularly in cases where children are thought to be at risk of non-accidental injury. This is understandable. Professional workers are increasingly blamed when a child in their care suffers from abuse or serious neglect. In the wake of the reports of the inquiry into the death of Maria Colwell, (DHSS, 1974), John Aukland, (1975), and the like, practitioners have become aware of their vulnerability to criticism for the alleged inadequate protection of the child. Thus we have seen the emergence of formal procedures for dealing with cases of suspected non-accidental injury: 'At Risk' registers, case conferences, codes of practice. In addition practitioners will develop localised efforts to reduce the uncertainty and protect themselves from criticism.

On two or three occasions the health centre participants requested information of a type which had major implications for social work and the social work relationship. Two examples come to mind. On one occasion a physician devised an informal 'At Risk' register of children drawn from the health centre's practice population. A request was then made to the social work department to supply the GP with the names and addresses of all of the children known to the Department who were thought to be 'at risk' and resident in the centre's catchment area.

Dr Craig: "I've requested the names of every child on the area team's 'At Risk' register who are living in our area. We should know about these cases. - Because we might become involved in the future. They refused to do this and I'm dissatisfied because they didn't do what I wanted them to do".

The second example was that of a health visitor who expected the department to inform her and her colleagues of any families new to the

area who had at one time been labelled as 'at risk' families.

It can be argued that the social workers' reluctance to release these details to the participants reflected their fear that such a move would lead social workers and others inexorably toward over-intervention in the lives of their clients and foster the growth of defensive social work. In their haste to criticise social workers for not complying with their defensive strategies the participants overlooked the interests of the social workers.

Confrontation and Information Exchange

It would be naive to assume that had the participants known and understood the occupational and organisation culture of social work, its policies and operational philosophies, that they would have been any less insistent that the social workers comply with their wishes. Without such an understanding however, there appeared to be little likelihood that they would develop a relationship with social workers based on mutual tolerance and reconciliation. As the social workers withdrew behind a barrier of silence and non-compliance, individual physicians responded with a confrontational style of presentation in the hope of 'forcing' social workers to comply with their wishes. Para-medical staff found these inter-professional confrontations particularly embarrassing and regarded them as counter-productive to the growth of reasonable working relationships. However, the participants also felt that in the short term confrontation occasionally produced results.

Sister Flower: "If certain members of staff feel the social workers are not being co-operative and won't discuss issues in an informal way then at the next meeting there's a blowout. I don't think that's appropriate. But that seems to be the only way to

get hold of the social workers to let them know how we feel".

Administrative Delay

- Dr Abel: "If we have to go through the social work department then we have to wait for days and days until they see the patient, if he's seen at all".
- Dr Baker: "When a decision is made and something, some action is to be taken on the social work side of things it seems to take weeks for anything to happen".

These comments typify the attitude of the majority of the participants towards the administrative structure of the social work department. The length of time the department took to arrive at an allocation decision or, having taken the decision, mobilise their human and material resources, continued to rankle with health service personnel. The emphasis that medical personnel placed on 'doing things' continued to act as a stumbling block to inter-professional co-operation.

Strategic Withdrawal

In addition to her role as educator another deputed function of the attached worker was to act as enabler and facilitator to bring the two groups together. An attempt was made to monitor the number of referrals made by the participants to the social work department. Unfortunately the method employed proved unreliable.⁽¹⁾ Secondary sources of information about referrals were also tapped but these too proved inconclusive. While personnel estimates of the frequency of referral made to the social work department are not noted for their reliability, it is nevertheless instructive that with the exception of one physician, all of the participants reported that their contact with the Department

had declined during the investigation. An unanticipated consequence of the attachment was that it created a situation whereby the various parties were able to increase the social distance between themselves by using the social worker as a 'go-between'.

The attachment reduced the sense of felt need experienced by the various parties to maintain contact with each other. As a result of the attachment the participants were no longer directly dependent on the department for social work services.

Dr Gold: "My feeling is that my major contact is with Jane. And having her here means that there is less need for contact with the area team".

Dr Deans: "I haven't made any referrals and I don't generally contact them for advice. Although I have asked for information from one area team social worker regarding an NAI. I was promised further information but it never came back. If I want advice or information I contact Jane".

Sister Flower: "I know that Jane is around a couple of days a week and I can ask her questions. So I haven't had to go through the machinery of getting in touch with them".

One physician, Dr Hall, suggested that after fourteen months of regular social work--health centre meetings, there was no longer any need to maintain them, that they were of only marginal utility if not irrelevant to his work with patients. A similar conclusion had been reached by those of his colleagues who had become irregular or non-attenders to the meetings. The decision not to attend the meetings was rationalised with reference to the attachment scheme:

Dr Hall: "Personally I think the meetings with the social workers could be scrapped. If I have any questions I go directly to Jane. I don't see much point in

dealing with the area team social workers as there are very few cases of mine being dealt with at 'the department'. At least to my knowledge there aren't".

This view of the meetings was not confined to the health centres. According to the attached worker, local authority social workers also used her as a 'buffer' between themselves and the centres. The attached worker said:

"The social workers don't use the social work meetings. If I'm up there (Social Work Department) I get asked about people's cases and I get asked about the details of the patient's illness. In a way I'm meant to have absorbed all of the medical details simply by being here".

Certainly the qualified social workers were, in the main, noticeable for their absence from the monthly meetings.

The attachment acted to sustain the sense of 'us and them' prevalent within the centres at the start of the programme. The availability of the social worker provided those with little or no commitment to developing a more positive relationship with the other agency with a convenient means of avoiding contact.

Attachment and Dependency

This is not to say that all of the participants were content with the apparent drift between the two organisations. The para-medical staff who had a more direct involvement in providing a service in the community, were especially concerned with their isolation from the department.

Ms Grant: "I feel as though I've lost touch with them. There are new faces up there and I don't really know

who's who. I don't really know what's happening in the area team. I've lost touch with them since the attachment. - Because most of the work is tackled by Jane. I don't feel that I know the social workers as a group and I feel that's bad. I see new faces all the time but I don't know who they are or what their names are. We're seldom introduced or told their function".

Others expressed concern that they had become dependent on the attached worker for social work services:

Dr Jones: "Ah, well yes I am concerned. The problem is that you get used to working with one social worker who works in a particular way. So when she goes on holiday and the work isn't being done by her it means we have to go to the area team. I guess it's appropriate to involve the wider team but I feel that, I have the feeling that when she's on holiday the system breaks down for two weeks".

Dr Kelly: "If we didn't have the worker on hand to give advice, take up referrals then we'd have to refer the case to the social workers at 'the social work department'. So the patient would be divided between the two services. Two services which don't have such good contact".

It was apparent that these concerns alone were not sufficient in themselves to motivate the participants to systematically develop their relationship with the department. While the health service workers recognised their dependence on the attached social worker and the potential problems this could pose to their practice, professional or organisational inertia meant that the participants did little to mitigate their situation. The attachment therefore acted as an additional source of potential disorder and instability to the development of inter-organisational and inter-occupational relations.

The Success of the Programme: The Participants' Response

Analysis of the data obtained from the follow-up interview and from informal discussions with staff suggested that they assessed the success of the attachment in generally favourable terms.

	Very Successful		Successful		Moderately Successful		Unsuccessful	
	H.C.A.	H.C.B.	H.C.A.	H.C.B.	H.C.A.	H.C.B.	H.C.A.	H.C.B.
GPs	0	2	1	6	4	2	1	1
Para-Medical	0	0	3	5	2	1	1	0
Total	0	2	4	11	6	3	2	1

The participants based in Health Centre B were, however, considerably more positive in their evaluation of the programme than their counterparts based in Health Centre A. A small number of participants regarded the attachment either as highly successful or unsuccessful.

The practical justifications provided by the participants for their evaluation showed that they tended to share certain assumptions about health centre practice and the place of attachment schemes in the provision of primary medical care services: attachment was seen as a means of satisfying their personal and professional interests and was conceived as a component feature of a broad practice ideology.

Physical Proximity

In common with Beal's (1976) study of the social organisation of health centres the results from the interviews suggested that the participants engaged in common sense theorising which resulted in a

causal link being drawn between the social actors' physical, or spatial, proximity within the building and the quality of their relationships. Firstly, the participants theorised that having the social worker based in the health centre had an impact on the frequency of contact which took place between actors.

Nurse Norton: "She's more at hand and we have daily contact with her normally. So I don't need to go up there (Social Work Department)".

Nurse King: "I'm happy that she's here because we know when she's around and she's easy to get hold of".

It was of interest that when they described the elements of the attachment which made it a 'success', the participants spontaneously compared and contrasted their experience of having an attached worker with that of working with the local social work department.

Nurse Park: "In a health centre, especially like this one, a social worker makes it easy for the patient to come to the surgery and be put in touch with a social worker quickly. So it works out that the case is dealt with much quicker than having them go to see an unknown person some distance away".

The social worker's spatial proximity within the building was thought to save both the professional worker and his or her patient time, relative to contacting the area team.

Nurse Curry: "If I have a particular problem, something I'm not sure about, I can discuss the case with her. It saves my time. If I 'phone the social work department they're either not in or the case hasn't been allocated. Really she deals with the question quickly".

Dr Baker: "We now have direct referral within the health centre. They (the patients) can actually be seen

in a few minutes or an appointment can be arranged for them to see the social worker in the next couple of days".

Spatial proximity was accorded a high rank in their estimation of the success of the attachment scheme insofar as the participants were able to 'get to know' the social worker. Spatial proximity was causally linked with 'knowing' the other party:

Dr Craig: "Having her here means that she gets to know you, and your (practice) problems and you know her. - Problem patients and their problems, the problems we have with some of the patients. Personally, I also think it's better to deal with the devil that you know rather than the devil you don't know".

Sister Edge: "At least we have open face to face contact. We can meet her here rather than 'phone and try and arrange things. If we're working under the one roof we all know one another and it's easier to talk to, to discuss, the patients with the social worker".

The physical proximity of the social worker within the centre also meant that the participants were able to employ to a greater extent the mode of communication which they most preferred, face to face discussion with the individual worker. The participants held the belief that they were better placed to exert more leverage over the other party and, therefore, more likely to influence the outcome of any negotiations they might have in face to face encounters with the individual social worker.

Nurse Art: "It's easier to get hold of her and talk face to face. It's much better than talking to an unknown person at the end of the 'phone".

Dr Lamb: "I don't really like discussing patients over the 'phone. Besides we get more feedback from the (attached) social worker about issues which are by their very nature sensitive".

Nurse Curry: "I think we have better liaison with her. I think the cases are dealt with quicker than if we went to the Social Work Department. She's around and she's available and we can discuss patients with her face to face. Also we can get more out of her than talking to someone at the end of the 'phone".

Organisational Constraints and the Organisation of Social Work Practice

It was with a good deal of relief and a great deal of satisfaction that the participants reported that the attached worker had adjusted to the occupational and organisational culture of medical practice, the collection of general principles, working rules and practices within which the daily work is accomplished. The attached worker dealt with the majority of the referrals herself, doing both long-term and short-term work. The participants were also pleased that the attached worker was geographically based, serving the same patient population as that covered by the centres, and they were particularly enthusiastic about having a single, identifiable or 'named' social worker to deal with rather than a 'team' of social workers.

Mr Miller: "The attachment has given us one person to contact and not an area team. It's given us a relationship with one social worker. We now have a name to ask for. Otherwise I'd have to call up and it would be a case of 'I'm not dealing with the case, so-an-so is and she's not here or she's in a meeting'".

The community psychiatric nurse went on to add:

"The whole point of the primary care attachment is that it's here and now. You don't have the delay when someone says 'I'll bring this up at the allocation meeting'. Whatever it is that social workers do she (the attached worker) can do it faster".

Nurse King: "From the health visiting point of view, she's available. You know who to contact or blame. It's

more satisfying dealing with one person instead of leaving messages and coping with the delay".

Dr Baker: "If one has any questions one can easily make contact with the (attached) social worker. You don't have to 'phone around the department to try to track down the relevant individual. Also the patients can deal with 'their own' social worker".

Dr Deans: "The main advantage I've seen over the year stems from her availability and the fact that you're dealing with a named person. It's very much easier if you've a contact person that you know who you can consult rather than having to ask 'May I speak with the duty social worker' and they tell you 'you'll have to wait'".

In addition, the participants formed the opinion that they had gained a member of staff who to all intents and purposes operated an 'on-demand' service.

Dr Kelly: "One of the indirect advantages is that when the patient is referred to the social work department they tend to open the case and at some distant point in time close it. At some later date it may or may not be re-opened. I feel that if you have someone on the spot then they are more flexible in their approach to problems. She's (the attached worker) there when she's needed. Perhaps this isn't the case but it strikes me that it's the case".

The fact that many of the participants felt that they were no longer dependent upon the local authority social work department for social work services did much to recommend the attachment. In their view, their newly acquired 'freedom' from the area team was thought to allow progress to be made in the development of the primary medical care system. In addition to these structural correlates the programme was thought to expedite rather than impede the facilitation of other interests.

Attachment and Professional Interest

A number of the participants, as other observers of social work attachment have concluded, (Corney & Briscoe, 1977b; Williams & Clare, 1979; Bursill, 1978) were of the belief that their patients benefited from the attachment. Secondly, the attachment relieved the participants of some of the uncertainty and the anxiety of dealing with the social work department whose structure was so difficult to understand.

Dr Lamb: "Certainly my anxiety level has been reduced. When I didn't have a social worker here I didn't refer patients to the social work department. I would either deal with the problem myself, probably not very well, or refer the patient to someone in the health centre".

Four of the participants, two health visitors and two GPs reported that the attachment had had the positive effect of reducing some of their workload.

Dr Fair: "I think it's taken the pressure off of me. — I'd have had to deal with some of the cases that I've referred in a supervisory fashion. Asking them (the patients) to come in for additional appointments to offer them long term support".

In addition, the social worker may have saved the participants' time in indirect ways. On the one hand the attached social worker may have expedited the rapid disposal of patients thereby reducing the need for additional follow-up surgery or clinic appointments. On the other hand the social worker may have reduced the number of occasions in which the physicians had to offer the patients 'special appointments' for more detailed in-depth investigation of the underlying problem and 'supportive' consultations.(2)

Furthermore, where two or more of the participants were involved the attached worker occasionally took over the role of 'key worker'. This meant that she took over primary responsibility for seeing to the immediate needs of the patient on the understanding that her colleagues could be called in for advice or to take over the key worker role at a later stage in the patient's career. The attached worker also saved her health centre colleagues time by taking on a case or providing information to staff members who would have otherwise had to carry out certain tasks and activities themselves.

Nurse Osborn: "I think that if there wasn't a social worker here I'd probably have had more work to do - rather than pass on the work to someone else that I didn't know, I'd have had to have spent more of my time looking for information on things".

Attachment as an Element of Professional Self Esteem

The attachment of a social worker increased the participants' sense of professional self esteem. It figures significantly in their accounts that they were able to derive a certain amount of professional satisfaction from what they saw as the positive reinforcing effect the attachment had upon their professional identity and professional image. The comments made by two health visitors illustrates this point:

Nurse Park: "I know that because I can refer the patient directly (to the attached worker) or I can go along and see the patient and let them know that something is being done, who they will be dealing with and tell them that I can get the information back to them. -- If patients approach you for something to do with a social work problem or for social work help you feel a bit of a silly saying 'contact someone in the social work department'. You don't know who to contact or whether or not they can do anything. The fact that with the attached worker here you know yourself that

something's being done, it makes you feel more relaxed. You feel like more of a professional".

Nurse Osborn: "You can say 'Miss Bishop can't see you now but she'll see you next week'. That gives me a better relationship with our patients because they see that you are doing something positive for them".

I have noted in an earlier chapter that medical education, with its emphasis upon 'doing' rather than planning and personal rather than collective responsibility, acted as a source of cultural conflict between health and social workers. The knowledge that they could call on the social worker and that she would 'do something' even if they were unsure what action she could or would take, was enough in itself to win their approval of the scheme.

In their day to day encounters with the patient the participants had to adapt to situational constraints and the necessity of getting through their work. The adaptations they were required to make in order to 'fit in' with the organisational and administrative structure of the social work department was perceived to have diminished their scope and opportunity for being seen as active professional workers by their patients. The attachment was therefore welcomed on the grounds that any adaptation that they had to make in order to work with the attached worker was within their definition of 'good professional practice' and approximated their ideal of how they ought to behave as professionals. In addition the intervention of the attached worker, on behalf of the referral agent or in response to a referral, was regarded by many as an extension of the services which they could provide to the patient. The attachment of the social worker represented a useful addition to the

stock of patient-management options available to the participants for the care and treatment of the patient.

Attachment and Job Satisfaction

The participants based on Health Centre B, unlike their counterparts in the other setting, expressed the opinion that the attachment had the positive effect of increasing their sense of job satisfaction. This was derived from the knowledge that once a referral had been made, action was being taken by the attached worker in the absence of the referral agent.

Nurse Park: "You can go out of the centre satisfied that someone is taking care of the problem. When you're not in a set-up like this it leaves you out on a limb. - Because you don't know if you can come up with the goods. Here you know you can get an answer to your question within a reasonable amount of time. Also there's someone on the ground and they understand what you're trying to do".

Unfortunately such trust was lacking in Health Centre A. This will be discussed in more detail later in the chapter. All of the participants benefited from what they saw as a reduction in stress related to uncertainty. Again the spatial proximity of the attached worker acted to reduce some of the emotional burdens of doing medical work.

Dr Ivory: "It's a comfort knowing that there is someone in close proximity to whom I can turn. To whom I can refer patients".

Dr Jones: "It's a colleague whom I'm likely to see during the course of the week. Probably two or three times per week. That helps to relieve my anxiety"

The attachment also helped to reduce some of the uncertainty and indeterminacy related to medical practice. (Atkinson, 1977; Fox, 1975).

Dr McAdam: "It's brought about a reduction in my anxiety level if you like. You know that something is going on but you're not sure what it is. It's the reduction in tension in those kinds of cases for which I'm very grateful. - Well, it's the fact that there's someone there, someone to whom I can turn for a second opinion. That reduced my anxiety. (Speaker's emphasis)

The attachment of staff therefore allowed the participants to share their uncertainties, their insecurities and the responsibility for patient management with the other workers. Some of the participants spoke of an increased level of confidence and security generated by this network of relations within the centre once the social worker had joined the team.

However, for those who had not achieved an acceptable working relationship with the attached worker, the poor level of professional communication acted as a new source of strain.

The Social Worker and the Primary Care Team

It is of note that the participants' evaluation of the 'social work' attachment's success was based less upon the performance of the incumbent worker and more upon the new organisation and structure of the work setting which followed. This point was not lost on at least one of the participants who commented at the end of the follow-up interview:

Mr Miller: "Considering all of the things I've said about the attachment and its success, liaison, quicker response, a named person, a bit of knowledge about her background and her interests. That really has nothing to do with the social worker. It's just about a social worker being here. It's difficult to know exactly where you stand with the social worker, with social workers and with social work - I guess you could call that a veiled criticism".

Despite the community nurse's qualification the data suggests that the social worker's performance in a collegial role had a decisive effect on the participants' evaluation of the attachment. The extent to which the parties felt that they had 'won' the commitment of the social worker appeared to be the single most important factor which differentiated the two health centre groups. The statement made by Dr Gold was typical of the comments made by the majority of the Health Centre B medical and para-medical personnel:

"I think, um, I feel that Miss Bishop is part of the scene really. You know, I personally found her helpful and she seems to have become part of the bricks and mortar of the place".

This sentiment was in complete contrast to the comments made by the Health Centre A participants as illustrated by one health visitor who observed:

Nurse Brown: "She hasn't really become part of the team. We need to see her more committed to the health centre. More committed to working with us".

The participants based in Health Centre A had never been happy with inequitable time sharing between the two centres (Health Centre A, 2 days, Health Centre B, 3 days), particularly as their centre served what was recognised by all of the local health and welfare services as a more disadvantaged area. In order to compensate for this structural constraint the worker needed to work harder in Centre A to earn a position in the team. In addition the unilateral decision taken by the attached worker, her senior and the area team leader to withdraw her services from Centre A in order to take up a full time post in centre B, presented fait accompli to the participants, did little to demonstrate

either her loyalty or commitment to their practice. The fact that both she and her senior fought with the local department to establish a second part-time social work post in the centre did little to mitigate the sense of betrayal. There were other factors to do with the attached worker's performance as team member within the centres which reinforced the participants' belief that she lacked commitment, and some of these have been identified. They included; her sporadic attendance at health centre meetings; her failure to participate and take an active part in various programmed activities and events; and her failure to develop informal, friendship-like relations with her health centre colleagues. The social worker's perceived failure to attend to these informal norms in the medical group were treated as evidence of her lack of interest in the practice and its practitioners.

Dr Elder: "I'm disappointed. Ah, in the end the hoped-for expansion of family work, preventative as well as curative if I can make that distinction, based on the psychiatric team simply has not happened. It hasn't happened because she didn't take an interest in the work we are trying to do".

Nurse Brown: "She should have been involved in the health centre meetings not just because she happened to be in the centre. I don't know if Jane really felt any allegiance to the health centre - to us - it's her attitude and manner. It's the way she talks about the centre and the time she spends in the centre. And what she does with her time. Especially her interest, or lack of interest, in the various meetings we have".

It is useful to conceive of attendance at practice meetings not simply as an outward sign of interest but, in the case of the centres under discussion, as a 'passport' into certain specialist fields of work. As I have argued elsewhere, the failure of the social worker to attend the psychiatric team meetings in both centres meant that she was

consciously excluded from certain interesting areas of work. As a result patients presenting with certain types of problem in which the social worker had declared a specific interest, were routed to those members of the team willing to make the concession to attend. In effect the social worker consciously broke the norms which were meant to be the source of effective social control within the centre.

The formation of inter-occupational ties was shaped and informed by a parallel development in inter-personal relationships. The formation of friendship-like relations was acknowledged by the majority of the participants as an important ingredient of successful inter-occupational work. At the start of the programme many but not all of the participants hoped that they would learn something of the social worker's personal biography, her tastes, interests and beliefs. By penetrating the professional facade, inter-occupational integration was thought to be expedited. Again the majority of Health Centre A respondents felt that they had made little progress in building an informal relationship with the social worker.

Ms Grant: "If you're part of a team then you've got to have a commitment to the other team members. You know them and they know you. Really I don't know what I've gained from the attachment. It's a difficult question to answer. I don't know, perhaps I haven't gained as much as I thought I would. I thought having another non-medical person about the place would be good. But the nature of the job takes her away from the building. Really her attachment here hasn't led to much discussion about non-patient things. The problem is I haven't been able to sit down and chat with Jane about non-medical things".

To her health centre partners the social worker neither followed the established norms of social interaction within the health centre,

nor had she negotiated new rules for social interaction in situations in which she found it impossible to comply with the existing normative rules. While the participants present in Health Centre A continued to maintain a positive attitude toward the concept of attachment they were less satisfied than their colleagues in Health Centre B and more cautious in their evaluation of its success. The findings suggest that while the attached social worker's standing and influence within the centres, and her ability to establish her professional credentials within the primary care team, was limited by structural constraints and her failure to acquire more power had much to do with her behaviour as a team member.

Latent Conflict and the Norms of Social Control

By and large the participants' criticism of and frustration with the attached social worker remained beneath the surface to affect their daily encounters with the social worker. For some of the participants the decision not to confront the social worker was influenced by their uncertainty of whether or not their views were shared by their colleagues.

Ms Flower: "I'm not sure what the problem is. I'm left with the question 'Are there problems with Jane or is it me?' Or do things work wonderfully? We have to accept that if there hasn't been, ah, if it hasn't worked then there's something wrong with the process. I'm prepared to accept some of the responsibility because I haven't spoken up but I think Jane has to as well".

Others provided the rationale that they did not wish to add to the burdens of the social worker by 'rocking the boat,' or as one GP reported:

Dr Ivory: "We know that Jane had a lot on her plate. So we didn't want to add to her work by making a criticism".

The data derived from fieldnotes and observations suggested another explanation for the doctors' and para-medical workers' behaviour. In his study of social control in a pre-paid group practice Freidson (1975) identifies the 'rules of (medical) etiquette' which inhibit practitioners from making public and private criticism of their colleagues' practice. Freidson (1975) writes:

Obedience to the rules of etiquette discouraged critical attitudes towards colleagues, the communication of critical information to others about the performance of colleagues, the discussion of critical evaluations with colleagues, and the undertaking of collective social control. (p.241).

An interesting feature of the two health centres under discussion was the fact that the rules of medical etiquette were relaxed and replaced by a normative system which actively promoted critical evaluation of their colleague's work and which did not discourage the expression of criticism. The practitioners made an effort to distribute information about their practice (through in-house research into their patterns of practice, group discussion about individual cases and a policy of open access to the patient's medical records) and made their work a topic for discussion and evaluation.

This system of collegial social control was predicated on a special type of relationship and attitude between the various parties: to confront and be confronted by one's colleagues was made possible by a spirit of trust and mutual respect. Such trust was often lacking in the

social worker's relationship with many of the health centre participants. In such a relationship the GPs and para-medical staff appeared to be more comfortable resorting to more traditional rules of etiquette. In addition they found it more acceptable to turn to the more traditional methods of social control, avoidance and boycott of the offending worker.

The Ideology of Attachment Revisited

I noted in an earlier chapter that the majority if not all of the participants exhibited an ideological commitment to the concept of attachment. Even those who were most critical of the attached worker's performance as practitioner and colleague did not weaken in their commitment to the concept of attachment, particularly as it related to a multi-disciplinary approach to patient care. For example, the GP in Health Centre B who found the attachment unsuccessful commented:

Dr Ivory: "On theoretical grounds I personally like the idea of a team approach to patient care. And the ability we have in here to meet fellow health centre workers on a face to face basis".

While the individual members of the primary care team may have differed in their perspectives of and their ideas about how the health centre should be organised (their operational perspective), they were united in their view that attachment was important on the grounds that the attachment of a social worker represented an additional service they could provide the patients.

Dr Craig: "We now provide a better service, a more rapid service. As for the standard of care I don't really know if the level of expertise is all that great. But maybe that's not important. It's a

gain rather than a loss. The patients and the practice have gained a social worker".

Dr Deans: "I've gained a useful service more than anything else. Although I'm not sure that I've learned anything about work and the social aspects of my patients".

Dr Baker: "It's an increase of the team by one which means a better service to the patient".

In recent years various occupational groups engaged in the provision of health and welfare services, doctors, nurses, social workers, educators have been exhorted to adopt a 'holistic' perspective of the patient or client, and to engage in a multi-disciplinary approach to service delivery. Medical practitioners in particular have been encouraged to regard the patient not as a physical entity, but as a 'whole person' who is affected by the social, cultural and material environment in which they live and to conceive of the patient as a complex entity of physiological, psychological, and sociological factors. The attachment of the social worker was seen to meet, or at the very least approximate, the ideal type of this new look practice:

Dr Lamb: "Having a social worker as part of the team does pay more than lip service to the concept of the 'whole patient'. I have the feeling that I'm providing a better service to my patients by being able to provide all of these services on the spot. Really it's the concept of the team working together in an effort to care for the individual in a whole sense and not primarily in terms of medical practice".

Dr Craig: "It's strengthened the primary care team which has tended with the exception of the psychologist to be illness oriented because we're doctors, health visitors and nurses. It makes a more, ah, life oriented approach or whatever".

The attachment effectively gave concrete expression to the concept of comprehensive primary health care provided from the single setting of the health centre.

Dr McAdam: "It makes the health centre more self contained. Not in a narrow sense but it's now possible to offer patients and clients a more comprehensive service".

For this group of health service workers the introduction of the social worker effectively filled the last major gap in the services provided from the centre: the health centre was, in their eyes, now 'complete'.

Nurse King: "Everything is now under one roof and we don't have to spend time sending patients somewhere else".

The participants appeared therefore to regard attachment whether of a social worker, community psychologist or health visitor as the appropriate 'technological' response to the problem of dealing with the 'whole patient'. Further, the participants could claim to be operating a state-of-the-art system of service delivery.

SUMMARY

Results from the follow-up interviews, informal discussion with the participants and direct observation in the medical setting suggested that the tension between the health centres and the social work department had diminished during the period of investigation. However, the relations between the health and welfare agencies did not reach the stage where they could be said to have actively co-operated with one another, nor did they co-ordinate their services to any degree. While it was not possible to test their assertions empirically, all but one of

the participants reported that their contact with the department by letter, telephone or in face to face discussion, other than at the monthly social work—health centre meetings, had become less frequent.

The majority of the participants continued to be critical of the direction, quality and the frequency of communication in the health centre—social work relationship. Indeed, an unanticipated consequence of the attachment was to confirm the participants' suspicions that the local authority social workers were highly selective with the information they chose to pass on. In certain instances by responding to the participants' request for more detailed information the attached social worker rather than generating a new understanding between social work and medicine, acted to heighten inter-agency conflict. They also remained critical of the administrative structure of the department, particularly as it related to the allocation of referrals. Both groups of workers relied heavily upon the attached worker as fact finder and information giver rather than make direct contact with the relevant individual: neither group attempted to 'trade' on the attached social worker's relationship with the other occupational group in order to increase their influence within the other organisation.

The health centre participants generally regarded the attachment as a success. There were, however, marked differences between the two centres in their evaluation of the scheme with Health Centre B personnel assessing the attachment in more favourable terms than their counterparts in the other centre.

The attachment was perceived to fulfil a variety of personal and professional interests and these have been identified; the participants

were able to disengage from direct day to day contact with the local authority social work department; the attachment reduced the pressure on doctors to carry out certain types of work; it increased the participants' sense of professional self-esteem; increased their sense of job satisfaction, and operationalised their idealised view of 'good', multi-disciplinary general practice.

The differential evaluation of the success of the attachment scheme by the health centres was accounted for on the basis of the participants' perception of the extent to which the social worker had provided collegial support and the perceived commitment of the worker to the centre, its members and ethos. It was interesting to note that while the participants were prepared to share their uncertainties about the attached social worker and her role within the primary care team with the researcher, they hesitated from openly confronting the attached worker with their views; putting the issue on the agenda.

It is hardly surprising that the health service workers, whatever their misgivings about the social worker's actual performance of her role, continued to support the concept of attachment to health centre settings. The participants, particularly the GPs, had discovered prior to the social worker being attached to their practice that this organisational arrangement was a highly successful means of advancing their interests. The doctors, and to a lesser extent the para-medical staff, gained personnel and professional status and were relieved of certain mundane functions as the social worker constructed her work around the work of the doctor.

The relative power of the participants has been assessed by

examining its consequences as it becomes evident in the decisions that are made and the non-decisions that were kept from the political agenda. I have also attempted to determine which social actors benefit and to what extent in contested decisions within the health centre. The data from the follow-up interviews suggested that the social worker was less successful than the GP at achieving the outcomes she preferred to decision issues and policy objectives.

The data presented in the last two chapters is of additional interest inasmuch as it also provides insight into the nature and use of power within the health centre setting. Looking back over the participants' response to the semi-structured questions and the remarks they made about their relationship it appears to me that, like the GPs, the social worker was not without access to an extensive range of structurally determined sources of power.

Firstly, the health centre workers, including the GPs, were aware that they were dependent on the discretionary services that social workers could provide. It is interesting to note that most studies which examine the sources of power within organisations emphasise the important role that dependency has to play in creating power (Mechanic, 1967; Whittington, 1983; Emerson, 1962; Blau, 1964; Thompson, 1967; Crozier, 1964). Here the power of the social worker is derived from having something that the health worker wants or needs, including; financial and material resources, knowledge of where voluntary and statutory agencies are located and how to contact them.

Secondly, the attached social worker's position was if anything strengthened within the health centre because of structurally determined

individual dependence. The medical practitioners had through their actions, increased their dependence on the attached worker, because they disengaged from direct contact with the area team. This meant that they had few alternative sources for obtaining the resources they thought were critical to their work and over which social workers had control. Ideally this should have placed the attached worker in an advantageous position to extend and enhance her power and influence in the medical setting. Further, given that her services were often provided informally this too made the higher-ranking participants dependent on her and thereby strengthened her position to bargain on issues which she regarded as important. Another potentially useful power resource was the participants' perception of her substitutability; she was not, according to the respondents, substitutable with any other known member of the social work department.

Thirdly, Freidson (1972) and Atkinson (1977) have drawn attention to the way in which doctors manipulate and use claims to uncertainty and indeterminacy in order to maintain their power over the patient and paramedical workers. This strategy of power acquisition was also open to the attached social worker. Perhaps as a result of their early experiences of medical training some GPs were particularly appreciative of the attached social worker's ability to deal with uncertainty by acting as an intermediary between the practitioner and the social work department. The social worker also acted as a consultant whom they could consult about patients whose social history and social circumstances were unclear. This too may be regarded as a structurally determined resource of power which the social worker could tap. The ability to deal with uncertainty in complex organisations, where there

is a high degree of task-dependency, like the health centre, has been seen by a number of writers as a source of differential power for the individual who is able to manage another's uncertainty (Cyert and March, 1963; Thompson, 1967; Hickson, 1971; Crozier, 1964).

Finally, as I noted in the previous chapter the social worker occupied a position on a key policy-making body, she chaired the monthly health centre--social work meetings. Here she was in a position to control the agenda, screening and defining what was to be discussed.

I am arguing that the social worker and presumably the paramedical staff could have engaged in a number of strategies, both tactical and strategic, such as controlling documentation, centralising expert knowledge and controlling externally based resources, to enhance their bargaining and negotiating position.

What, then, could the social worker have done to enhance her position? If we accept that the power of different occupations in the medical setting is at least in part a consequence of a hierarchy of authority of expertise, rather than concealing her work from the attention or 'gaze' of the doctor the social worker could have acted to selectively publicise and promote the work she had accomplished with certain categories of patient, e.g. those defined as problem patients by the doctor. On the other hand, given the ignorance of the practitioners of the resources that were available outside of the centre and how to make use of them, rather than 'teaching' the medical practitioners about these agencies and how they are organised, the social worker could have, like Crozier's

maintenance engineers, maintained her monopoly over such knowledge. Another way of stating this proposition would be to say that she could have attempted to control the doctors' uncertainty. In addition, with the active complicity of the doctors, the social worker could have managed the extent to which they regarded her as substitutable, e.g. emphasising her unique position within the primary care team.

Such strategies for the use and acquisition of power in the health centre rely upon the political actor being knowledgeable about how the medical setting is organised and how power is distributed amongst the various occupational groups. The effective political actor must also know something about the rules and norms of power usage within the medical setting. He must also be aware of his own sources of power and he must also be prepared to engage in strategies, both tactical and strategic, which are geared to the acquisition of power.

What is under discussion is a variety of structurally determined sources of power which the social worker could have used when bargaining and negotiating with the medical practitioners. Obviously, the empirical evidence supporting these theoretical statements is far from complete. There needs to be a direct way of testing the various assertions. For example, in regard to the resource dependency model put forward by some writers this could be done by examining the effect of outside resources on the power and influence of social workers over time as the scarcity and decisiveness of resources vary. While such research would be valuable to our understanding of the resources of power within the medical setting, the point that I am trying to make here is that neither the social worker nor for that matter the other subordinate

workers, seriously attempted to 'test' whether or not they had power and influence in relationship with medicine.

Like Goldie (1977) I am arguing that:

While the division of labour may have been imposed by the psychiatrists (or GPs) it continues to be maintained by the very staff who occupy an inferior position. (p.159).

It is my contention that in order to understand the division of labour and the nature of power relationships we need to take into account the constraints and resource contingencies facing the political actor, whether individuals or groups, and their ability to advocate their skills and capacities for dealing with these contingencies, how well they are able to shape the definition of the situation, and their knowledge and advocacy skills that help in the exercise and deployment of structurally derived power.

This suggests that we require an 'advanced intellectual synthesis', to use Freidson's terminology, which can take into account both constructivist and interpretive approaches to the study of inter-occupational relationships in primary medical care.

CONCLUSION

The study has centred upon two groups of health centre participants who, for a variety of reasons, wanted to have as part of the primary care services an attached social worker. The investigation also examined the experience of a social worker as she attempted to negotiate, or bargain for, a place within the social organisation of the health centre.

The various occupational groups who were directly affected by the attachment programme, the doctors, para-medical workers and social workers were found to differ in terms of the interests and the objectives they hoped it would achieve. Differences in their respective perspectives of the attachment scheme were, in the context of this study, treated as key issues which required bargaining and negotiation in order to resolve differences. Further, I argued that the ability of the social actors to achieve the outcomes they preferred would give some insight into the nature of power relationships within the health centre.

The investigation is an exercise in descriptive power analysis. In it I hope to have shown the value and importance that a description of power relations has to play in an understanding of the social organisation of health centre practice. In addition I hope to have given some idea of the results of patterns of power too complex to deduce from the existing literature. The study is also meant to have provided information of some inherent evaluational interest.

The Health Centres in Context

In this discussion of the relationship between the doctor and the

attached social worker one must be cautious in making generalisations from what is, after all, a case study. In addition, the two health centres differed in some respects from other GP group practices and health centres found in Britain. I mentioned in the introduction to this thesis that the GPs held conjoint appointments: they practised as general practitioners within the health centre and as specialists within the local hospital. This arrangement provided the GP/specialists with the opportunity to bring their 'hospital work' into the health centre, e.g. although the Sexual Dysfunction Clinic was ostensibly a hospital based service, the GP/psychiatrists ran their clinics from the health centre. Thus the health centres occupied a position which spanned the boundary between general practice and hospital practice.

Horobin and MacIntosh (1977) note the marked variation in the way in which GPs conceptualise and interpret their work, their field of responsibility, and the impact that this has on their practice: there were what the authors called the 'family doctors' who wanted to do all of the work themselves - counselling, 'social work' and doctoring. There were others, defined by the authors as 'primary physicians', who had a narrow conception of the general practitioner role, who wanted to deal exclusively with medical problems', who wanted to refer patients with 'social problems' to the social worker.

From my reading of the literature, Horobin and MacIntosh (1977) and Mechanic (1975), and my experience of GPs in other health centres, I hypothesised that both types of practitioner would be found within the two health centres. That is I expected to find a range of views amongst the general practitioners about the role and responsibility of the general practitioner and a range of ideologies relating to the nature

and purpose of general practice. However, what I found was entirely different from what I had expected: all of the doctors were, to varying degrees, committed to the ideology of 'whole' patient care based upon a multi-disciplinary approach to practice. It was not clear whether or not this ideological hegemony was the result of selection, socialisation, indoctrination or a combination of all of these mechanisms. What was clear, however, was the important part that this belief system had to play in shaping the social organisation of the centres and its impact on inter-occupational relationships.

The point that I am trying to make here is that the 'clinically' oriented GP may be content to sit in his surgery and deal with the patient's physical complaint. Such a doctor might think that he had little need to work with social workers, or for that matter, health visitors, on the patient's social problems. The more 'socially' oriented practitioners, however, because of their concern for the 'whole patient' saw a need to work with a wide range of para-medical and lay occupations. Because of their ideological commitment to whole patient care the GPs, like hospital doctors, were faced with the need for coordinating the performance of complex collective tasks.

Firstly, both groups of medical practitioners had introduced a system of collegial control (Freidson, 1975) which enabled the health centre participants, GPs, para-medical and lay workers, to monitor and evaluate each other's work. They carried out in-house research into their patterns of practice. They openly discussed their diagnostic and clinical performance in relation to individual patients. And, they paired with a colleague to provide general medical services to a defined segment of the patient population. This meant that each practitioner's

work was scrutinised by their partner. Generally speaking the doctors communicated more information about their work with patients than one would expect to find in other general practice settings.

Medical Dominance

Like the hospital doctor (Freidson, 1983), the health centre doctors also tended to abuse power; that is their power tended to spread from the situations in which it had been legitimated to other situations which served their collective and individual interests. Yet, despite the broad similarities between the two groups of physicians, they differed in terms of the nature of their relationship with the patient and the kinds of structural constraints they had to work within.

As Horobin and MacIntosh observe:

Whereas hospital doctors are relatively encapsulated in a 'medical' world - GPs are subject to a greater variety of inputs from the non-medical world of their clients, and other agencies with which they share boundaries - social work, 'welfare', public health, etc. In other words hospital doctors are more free to construct their professional world in professional terms: the GP's world is wider, more permeable to influences from without the medical profession. (p.90)

For this and other reasons, explanations of the power relationship between occupational groups, particularly when one of the groups is medicine, which are derived from the hospital setting and the hospital experience are of limited explanatory value when applied to the health centre setting.

For example, Freidson (1970) argues that the dominance of medicine over other subordinated occupations within the hospital is achieved not

least from the fact that within the hospital the work of the subordinate cannot be initiated without the agreement of the physician:

Without medical authorization little can be done for the patient by para-medical workers ... The para-professional worker is, then, like the industrial worker subordinated to the authority of others. He is not, however, subordinated solely to the authority of bureaucratic office, but also to the putatively superior knowledge and judgement of professional workers. (p.141)

This statement captures for me the salient features of his concept of medical dominance. The authority of the hospital doctor is derived from an amalgam of his socio-legal responsibility for the care of the patient, his 'office' or place within a structural hierarchy and, most importantly, his knowledge and expertise particularly as it relates to problem solving.

Yet Dingwall (1980) has shown that Freidson's account of the influence and authority of medical practitioners within the context of the hospital, where the para-medical worker is dependent upon the consultant for all of his work, may be of limited heuristic value when applied to general practice. Health visitors, he points out, are less dependent on the doctor for work as a result of their statutory responsibility for health care and health promotion amongst a demographically defined population. Although I have argued that the health visitors' autonomy from medical control is mediated in concrete situations by the outcomes of their negotiations with the doctors and the structure of their relationship to individual practices within the health centre, the importance of Dingwall's findings is his suggestion that lower level participants in primary medical care are not without

structural resources of power.

Freidson's model of inter-occupational relations is especially problematical when one attempts to apply it to the medicine--social work relationship. Although the GPs represented the single most important source of work, unlike the health visitors and the other para-medical workers the attached social worker was far less dependent on a small number of physicians for referrals. Put another way, the structural position of the social worker within the health centre meant that she had many more options to choose from for rewards than her subordinated colleagues.

It seems to me that by concentrating upon the competent and legitimate authority of medicine Freidson is putting forward a command-obedience model of power relations. That is the subordinate worker is thought to gear his conduct to the doctor's wishes, his preferred outcomes, and carry out his commands because of the source of the communication and the content of the communication. This latter point is especially problematical in explaining the social worker's behaviour when one recalls that one of her own preferred outcomes was to 'demedicalise' a proportion of the doctor's practice in order to supplant it with a social work frame of reference and frame of relevance. It is, therefore, unlikely on common sense grounds that the social worker would be swayed by the doctors' claims to superior knowledge and expertise.

In addition, the data suggests that while some of the physicians may have expected subordinate staff to treat them in an authoritative manner (and this became most evident in their comments about the social

worker when they were unable to win her compliance to their wishes) they did not rely upon claims to expert authority as a primary mode of power and influence in relationship with other occupational groups. Rather they either consciously or unconsciously deployed a variety of strategic and tactical strategies designed to enhance and extend their power and influence over others. These included; inducement, coercion, persuasion, negotiation and participation.

Nevertheless, the results from the study of the attachment process, as many studies have done before this, show that the doctors were the most successful occupational group at achieving the outcomes they preferred. They also managed to block the social worker from achieving the operational and political objectives she desired.

The findings indicate that while in relation to social work, and to a lesser extent health visiting, the GP may have lost his legitimate authority to direct and control the work of the social worker, once the social worker was attached to the health centre, medicine's power and influence once again become manifest.

The Power of Lower Participants

This is not to argue, however, that the social worker is without structural sources of power. The social worker occupied a position within the organisation which gave her structural power; she had control over resources, she was difficult to replace, she dealt with areas characterised by medical uncertainty and so forth. Yet she chose not to engage in power acquisition, and, as a result, her view of the social world, her goals and definitions did not, in the main, prevail over medicine. Indeed, her behaviour reinforced the unequal distribution of

power within the medical setting. The social worker regarded herself as relatively powerless and the doctors as powerful. Although subordination and low status was experienced as unpleasant, the para-medical and lay staff appeared to accept, like Goldie's psychiatric social workers and clinical psychologists, their inferior status as a necessary part of the job. Thus, while the subordinate staff were offered the opportunity to challenge the doctors' assumptions, the physicians met with little critical assessment of their definition of the patient, the role of the para-medical and lay worker or the structure and organisation of the health centre. Following Goldie, I am suggesting that the intentionality of the subordinated worker, their sources of power, both structural and personal, and the behaviour of the doctors, intent on extending and enhancing their control within the medical setting, must be taken into account when attempting to explain power relations and the division of labour in primary medical care settings.

It is an obvious point, but one which must be addressed, that the attached social worker's capitulation to the doctor might be no more than what one would expect of a relatively inexperienced lower level member of staff. Yet as I mentioned in an earlier chapter, the attached social worker's behaviour was not dissimilar to the actions of experienced members of the social work department including the senior social workers. Unfortunately the constraints of time and space have not permitted the inclusion of a detailed analysis of the health centre--social work meetings. Direct observation of these events indicated that the senior social workers and many of the qualified basic grade workers tended to avoid these meetings (disengaging from contact)

and when they did attend they avoided direct confrontation with the doctors. Indeed, even the executive social workers' attitude and behaviour toward the doctors shared the same features as those of the lower level participants: they ignored open confrontation with the practitioners and when they advised the attached social worker on political tactics and strategies they tended to be of a manipulative kind.

Field Specificity : The Limits of Medical Dominance

Another factor which appears to be missing in much of the writing to do with medical dominance is a recognition that the power of the medical profession, particularly in general practice, is limited in terms of its comprehensiveness, the number of people who are subordinated to the doctor, and its intensity, the number of fields or situations in which they are able to obtain the compliance of the other person. That is the doctors were not always able to achieve the decision outcomes they preferred, nor did they exercise total control in the organisation.

Once the attached social worker had become accustomed to the medical environment and perceived that the doctors were attempting to extend their power into situations which she thought were a part of her legitimate domain she took steps to minimise their control. She made a variety of decisions which had the consequence of restricting their control - for example, she concealed her activities from their gaze and disengaged from contact. The consequence of these decisions was that the spread of the doctor's control was 'checked'; they failed to establish contact control over the social worker, developing and

maintaining a relationship with the social worker, and they were unable to supervise and direct the social work--client relationship. The social worker was therefore able to exercise autonomous discretionary judgement in relation to the patient, deciding which tasks should be carried out and which immediate goals were to be pursued in concrete situations. The social worker was also able to decide independently of the doctor, what and how something was to be done. She thus demonstrated both strategic and tactical decision making despite the doctors' attempts to gain control over her behaviour, both thought and action.

On the basis of these and other related data I am arguing that models of power relations derived from the hospital are of limited value in explaining the power relationships within general medical practice. This may stem from historical and structural differences between the two medical settings.

It is only in the past twenty years or so that GPs in Britain have been joining together to form groups, to employ ancillary staff and to establish full time attachment posts of para-medical and lay workers. Many of the occupations who work in primary medical care, notably the health visitors and social workers have during this period of change established governing bodies, administrative structures and contractual arrangements with their employing authority which are independent of the medical profession. As a result, general practitioners are only now being faced with the problem of coordinating a complex, multi-disciplinary group of semi-autonomous workers.

Further, the structured power relations within the hospital

consisting of rules and practices handed down from the past are, to a certain extent, lacking in the general practice setting. That is, the weight of tradition of routinised ways of acting may not, as yet, be firmly established and may, for a variety of reasons be challenged by certain occupational groups should the general practitioner attempt to establish such routines. I am, therefore, arguing that accounts of power relations which give primacy to the authority of the doctor to direct and control the work of other occupational groups is problematical when applied to general practice.

The study suggests that as yet we are some distance from being able to make with confidence statements about power relations in general practice and its impact on the social organisation of general practice. The investigation reveals a need for more complex theories about the nature, distribution and disposition of power relations in general practice which can stand the test of empirical validation.

It seems to me that in order to understand the nature of power relationships within medical settings we need to develop a perspective which enables us to draw connections between social and historical processes on the one hand and individual biographies on the other. That is, we need to situate the individual in a social context, to say something about the context in respect to its internal structure and dynamics and to assess the opportunities it makes available and the constraints it imposes on individual action. At the same time we need to take into account the individual and the uniqueness of the individual within the context of certain social and material givens. Again, I hope the study has indicated that structural constraints do not completely determine the actions taken by individual actors in the

context of medical settings: the individual is not simply a prisoner of some supra-individual forces entirely beyond his or her control. Such a perspective retains the idea of the social actor as an active, intentional subject while socially locating him or her within a context which may resist, block or thwart his or her attempts to achieve what they want.

Some might argue that from a theoretical and methodological point of view this is an inordinately individualistic construction of power. Yet it seems to me that the approach allows one to consider how one gets from one situation to another, how struggles occur and who wins the battle. Without a sound knowledge about the mechanisms that operate at an individual level, macro-level analysis will be condemned to the speculative. In other words, this approach to the study of power relations could provide a solid foundation for the development of macro-level theory.

A P P E N D I X A

NOTES

INTRODUCTION

- (1) Institute fur Medizinische Soziologie, Medizinische Fakultät, Albert-Ludwigs Universität, Freiburg im Breisgau, West Germany
- (2) A sample of final year medical students were canvassed in 1966 by The Royal Commission on Medical Education (Todd Report). The Commission found that only 23% of the sample expressed an interest in entering general practice.
- (3) The number of full-time principals in general practice in Scotland remained constant during the 10 year period from 1952 to 1962 at approximately 2,900 principals (Tavistock, 1972). By 1966 the number of principals had dropped to 2,594 full-time principals. From 1966, the number of principals rose to 2,900 where it has remained relatively constant.
- (4) The speed and scale of the health centre development programme appeared to take the profession unawares. It was not until 1978 that the General Medical Services began thrashing out a basis of GP policy toward health centres. (General Practitioners, 1978, p.1) The planned development of health centres in Scotland was expedited by virtue of the fact that under the National Health Service Act (1946) the Secretary of State was charged with the responsibility for setting up health centres in Scotland which may have allowed Health Ministers to engage in a more coherent programme of planned national health centre development. In England the responsibility was placed in the hands of the local authorities.
- (5) The choice of setting for carrying out the research was made on purely pragmatic grounds. A lecturer at the Department of General Practice, University of Edinburgh, suggested that the two centres were the only likely sites that he could think of that would accept a graduate research student.
- (6) This did not simply represent what Lacey (1976) has defined as the 'participant observation syndrome': the common feeling that the 'real' action is going on somewhere else. It was in the doctor's consulting room, the nurses' office and the various health centre meetings that the staff members came together in face-to-face contact. For the most part inter-occupational contact between the participants in public and semi-public places, eg the hallways, reception areas and coffee lounges, the areas of the setting to which the researcher had free access, was limited and when it did occur was very often characterised by a stilted highly formal relationship.
- (7) In addition the attachment served a number of other long-term interests which were beyond the scope of this study. The executive officers were of the opinion that the experimental attachment of social workers to secondary settings would:

- (i) improve the 'image' of social work ('de-stigmatise' social work) in the eyes of other professional workers and the public;
 - (ii) facilitate the future development of new attachment schemes elsewhere in the Region;
 - (iii) provide an opportunity to link the Social Work Department with the Health Board at the executive level; and
 - (iv) improve the quality of services provided to a patient/client population.
- (8) At the time of the study, the average list size of the Region's general practitioners was 1,800 patients and 2,200 for Scotland as a whole. The average list size of the doctors based in the New Town was approximately 1,400 patients.
- (9) Such methodological problems were most evident when recording the 'oral histories' of the respondents, i.e. when carrying out in-depth interviews for the purpose of eliciting retrospective data referring to events taking place before the time of data collection (Hindley, 1979). Despite the weaknesses and the many methodological problems it presents, like any other method either quantitative (Hindes, 1971; Atkinson, 1971) or qualitative, such data provides useful information and insight into various aspects of the respondents' lives and their experience of work. At the same time this method of data collection allows the researcher to explore the respondents' ideas and beliefs about past events.

CHAPTER ONE

- (1) Jamous and Pelloille (1979) note that as a result of challenges by clinical and para-clinical researchers in the French hospital system during the 19th century to medicine's claim to monopoly over knowledge, hospital clinicians maintained their social and professional superiority by claiming that their pre-theoretical clinical experience, their 'practice wisdom' (Atkinson 1977), set them apart from those who participated in the generation of medicine's substantive body of knowledge.
- (2) Butrym (1974), for example, warned her social work colleagues that social work may be in danger of vacating the field of 'personal relations work' and 'emotion work', and thereby allow the field to be colonised by other professional groups. In such ill defined areas of practice it is possible to argue that 'everyone' can obtain more control.
- (3) An examination of the appropriate literature revealed a number of different approaches to the study of power. The first is concerned with theoretical analysis of the notion of power and its related concepts (Dahl, 1957; Lukes, 1974). The second is concerned with

descriptive studies of power systems at a societal level of analysis (Dahrendorf, 1959; Mills, 1956; Weber, 1947, 1968; Marx, 1962). The third is based on laboratory studies under controlled experimental conditions (Oldham and Brass, 1979; Staw and Ross, 1980). The fourth approach aims to study power relationships empirically in real situations. This thesis falls within the fourth approach to the study of power relations, it represents a descriptive analysis of power relations within the context of a particular setting, the health centre.

- (4) This approach was not without its problems when put into practice. Firstly, it became apparent from the start of the study that the identification of the individual's preferred outcome vis a vis the attachment programme and the social worker's role in the primary care setting relied upon the individual being aware of the outcome they preferred. It was plain that in some instances the respondent had no clear idea of what outcome they preferred. This initial problem was mediated as the attachment progressed and the participants became aware of their preferences in contrast to what they were experiencing.

Secondly, influence and power processes were manifest in only a small number of day-to-day inter-actions. Many of the inter-actions were related to the simple exchange of information and others were straightforward command-obedience inter-actions. It was necessary to collect a large sample of negotiating inter-actions and negotiating positions from which to draw a sub-set in which power and influence came into play.

CHAPTER TWO

- (1) There are various reports of improved co-operation and communication between social work and medicine when sustained by informal contacts. These positive contacts are disrupted and result in frustration when there is a situation of high staff turnover or organisational change (Goldie, 1977; DHSS, 1979; Satyamurti, 1981).
- (2) There is much empirical evidence which challenges this idealised model of general practice and the role of the general practitioner within primary care (Stimson and Webb, 1975; Stimson, 1978; Stacey, 1976).
- (3) Dingwall (1976; 1977) regards the use of 'atrocious stories' which circulate within different occupational groups as a device which allows social actors to ventilate their feelings of anger and frustration with other occupational groups.
- (4) A community psychiatric nurse commented:

Mr Miller: "At the same time (the meetings with the area team were coming to an end) there were problems in the area team; they went through changes in their professional staff with staff leaving. Without the liaison officer there was no getting feedback. The

expectation of the primary care team was that the change hadn't really altered the social work department who saw it (the liaison worker) as an added responsibility. It was very much the social work department who said 'we don't have the staff and we can't manage having a liaison worker'. We were saying that this liaison post didn't mean an increase in workload and it might even mean that in the odd case the social worker could be withdrawn".

Such attitudes as these may have been regarded by the social workers as an outward sign of the insensitivity of health workers to their plight.

- (5) The health centre participants justified the use of the health centre on the grounds that more staff attended from the health centre than the social work department and that the Department did not have the physical space to accommodate a large meeting.

CHAPTER THREE

- (1) Take, for example, the comments made by the Cohen Committee (Central Health Services Council, 1954):

General Practitioners must hold a key position in the health service and this means in effect that the prestige and remuneration of general practitioners must be such that they do not compare unfavourably with the prestige and remuneration of other professional workers in the service.

- (2) Within a week of the appointment being made this informal agreement between the executive and administrative grade workers was reversed. The Area Team Leader was informed that the settling in period had been cut to one week, a decision which found little favour with the Team Leader among others:

Ms Argent:

"At first I thought that she would be with us for a month, then I got a letter saying that it would only be for a week. I held out for a fortnight so that she could become involved with everyone. You know, for her to get to know everyone and we could get to know a little about her. Personally, I don't think (Mr Green the administrative officer setting up the programme) should have responded to the pressure from the doctors. I personally don't think that he should have done so, it would have been better for everyone to have kept to the one month period".

In fact, interviews with staff revealed that pressure to cut the attached worker's time in the area team had not come from the doctors. Rather the decision to reduce the period from one month

to one week was argued between the basic grade worker and the Regional Administrators. As I shall demonstrate later in the report, this decision both highlighted administrative confusion surrounding the attachment programme and had an adverse effect on the development and success of the attachment scheme.

- (3) Eaton and Webb (1979) use the term 'demedicalization' to describe a process whereby medical practitioners willingly relinquish territory and delegate tasks to subordinate occupations. For the purpose of this discussion I use the term in a more dynamic way which includes the ability of the social worker to persuade physicians that social work can take the place of medical practice in the treatment and care of the patient. Thus the attachment was seen as an opportunity for the social worker to argue, appeal, or exhort medical practitioners to accept the social worker's communication as the basis of their own behaviour.

CHAPTER FOUR

- (1) The social workers may have wished to avoid creating expectations about the social worker's role which the social work department was unable to fulfil. It will be recalled, however, that the hesitancy of social workers to clearly define their unique contribution to the care of the individual and to describe what social workers actually did in their transactions with the client was a source of acute frustration amongst the health centre participants.
- (2) Some social work training establishments may, however, be reinforcing just such a view of social work practice. In the absence of shared agreement as to what constitutes the 'core' skills and knowledge of social work practice emphasis has been placed within at least one Scottish educational institution not on training per se (the inculcation of skills thought to be necessary or essential to the practice of social work) but on the personal development of the student (the enhancement of some notional idea of the personal qualities of the student which are thought to be necessary for the practice of social work). (Irvine, 1982).
- (3) It can be argued that the social worker, by adopting this particular definition of her role, bows to and places herself under the authority of the GP: she sees herself in the business of saving the doctor time at the expense of her own. Thus, by definition, the social worker cast herself into the role of 'handmaiden to the GP' before she actually entered the health centre and as such reinforced the doctor's authority in the medical setting.

- (4) It appeared that the health service workers' views and understanding of social work practice were in many respects similar to those of clients reported in other studies (Mayer and Timms, 1970; Rees, 1975). The clients of social workers have been shown to associate social work with practical problem-solving and they had little idea of the additional services that social workers could offer. This image problem is perhaps exacerbated in certain circumstances by the fact that social workers do help to ameliorate problems of a practical nature. It appears that social work tends to present a somewhat vague and unclear image to the world at large.

CHAPTER FIVE

- (1) The Social Work Department's senior executive officers insisted that the attached social worker take up referrals where there was evidence of physical or psychological pathology. All 'purely social problems' were to be channelled to the local area team for allocation.

CHAPTER SIX

- (1) From the start of the attachment the social worker lacked a room of her own within the centres. Like the trainee GPs and trainee paediatric students she was allocated an office of one of the other participants as and when it became available. Her displacement from one room to another undermined the worker's sense of well being within the centres. "At times I feel like a nomad". On other occasions she felt like an outsider who constantly made demands on the established members of staff:

"Hm, it's having a space of your own. That would make identification much easier. If you have a room of your own you feel like a part of the place. I don't have my own room in either place which makes me feel a bit uneasy. It makes you feel as if you might be putting someone out".

On occasion the social worker was allocated a room which was already in use by its 'owner'. In such circumstances it was the social worker who was forced to withdraw and search for alternative accommodation. Having occupied a room she was subject to interruptions when the 'owner' returned to retrieve notes, collect files and so on. Such interruptions were particularly annoying when they occurred during interviews with the patient, when mediating with external agencies by telephone or when writing up case notes. This situation also added to the worker's sense of insecurity within the health centre.

- (2) Other lunchtime meetings which were held in both health centres included promotional lunches sponsored by drug firms interested in pushing a new product, to which all members of staff were invited, and the monthly social work--health centre meetings.
- (3) On at least one occasion doctors from an outlying practice attempted to solicit the help of the social worker in an attempt to by-pass direct contact with the area team. The doctors attempted to 'trade' on the relationship that their colleagues in the attachment centres had established with the social worker.
- (4) The term inclusion comes from Dingwall (1983) and is used by him to describe the 'jostling' for self-esteem and attempts by some occupational groups to assert relationships of superiority over some occupational groups and to attain equality with others. I shall use the term to describe the attempts by occupational groups to get other occupational members into relationship and, having achieved this, keep them in relationship.

CHAPTER SEVEN

- (1) At the time of her appointment the area team was under preasure as a result of a shortage in manpower. Two of the team's senior social workers, one of whom agreed to act as her supervisor, were preparing to take up new appointments elsewhere.
- (2) This arrangement was the result of the quid pro quo negotiations with general practitioners. The GPs agreed to allow the attached worker access to medical records so long as her case records were kept within the centres. GPs were also concerned that certain pieces of information contained in medical records did not find their way on to case records over which they had no control.
- (3) Selectivity bias in case presentation in supervision may represent a general problem within social work. As Parsloe and Stevenson note:

"8-6 ... while social workers were in general very clear about the necessity to share non-accidental injury with team leaders, they had difficulty in spelling out what other types of case or situation should be shared, few authorities laid down any guidelines". (DHSS,

1978)

- (4) There are those who argue that in situations where the supervisor offers his tacit approval of the work carried out by subordinates, in the absence of discussion and planning, the supervisor becomes legally accountable for the actions of their staff:

"The team leader remains accountable for the decision he must make or approve (my emphasis), by 'rubber stamping' some decisions on the basis of his confidence in the worker he will run some risk". (Pettes, 1979).

Had some serious mishap occurred the supervisor and the area team leader may, therefore, have been put in serious jeopardy.

- (5) On a number of occasions the two senior officers were seen to differ in their views of how the programme should develop. Consequently they gave their professional staff different, conflicting messages. This too added to the tension and strain experienced by fieldworkers as the attachment progressed.
- (6) The attached worker's view of the allocation process within the area team was interesting in its similarity to the comments and observations made by medical workers prior to the commencement of the attachment programme. Broadly speaking the attached worker can be said to have adopted a "medical perspective" in her criticism of the local department's structure and function.
- (7) The worker's demand for upgrading was based on the fact that the second attachment was to only one centre. As such, her demand took into account structural differences between of the attachments rather than a consideration of the professional experience, expertise, and competence of the worker, factors which are typically associated with deliberations concerning the promotional prospects of the individual worker. (Hey and Rowbottom, 1977).

CHAPTER EIGHT

- (1) Of the three doctors who made reference to the social worker's consultancy role only one physician, Dr Hall, felt able to describe the conceptual differences between the social work and medical model of practice. The remaining participants simply regarded the social worker's viewpoint as 'different' from their own.
- (2) A consideration of values or social work value systems usually forms a part of any discussion about the profession. The number of attempts to systematically investigate the subject are, however, few. Whether or not practising social workers in fact hold the

values and attitudes espoused by their trainers and spokespersons remains subject to empirical validation.

- (3) On the basis of my own experience of the participants during fourteen months of field work, and on occasions thereafter, their claim to be interested in and appreciative of debate and argumentation about matters of general interest and matters pertaining to the centres and the patient were substantiated. The doctors in particular liked to engage in debate and appeared to use these events as a source of information about the personal views and beliefs of their 'opponent'.
- (4) Prior to the start of the attachment programme a meeting had been organised in Health Centre B to discuss the role of the social worker. According to informants within the health centre and the local department, the social workers focussed upon certain types of problem and/or client group, e.g. bereavement, the terminally ill, the handicapped, and attempted to describe the social worker's function vis-a-vis the problem/client group, e.g. support, counselling and so on. This was a curious way of dealing with the question of what do social workers 'do' which runs counter to the spirit if not the letter of the approach for identifying and describing social work recommended by such representative bodies as BASW, which notes:

5.5 ... There is no single role which is unique to social work - non-social workers will quite properly carry out each of them ... it is not the roles alone, therefore, which determine whether or not social work is being undertaken. The context in which these roles are performed, the constellation of purpose, values, knowledge and sanctions, is the determining factor.
(The Social Work Task, p.34)

Needless to say, this particular encounter between the social workers and health service workers generated more heat than light. Both groups retired to their respective corners to complain bitterly about the other's comments and response to the discussion.

CHAPTER NINE

- (1) The participants were asked to keep a running record of the cases they referred to the social work department during the enumeration period. Unfortunately this request combined with the other demands made on their time proved too difficult to fit into their practice routine.

- (2) It was a common practice in both centres for the physicians to offer certain patients non-routine, twenty or thirty minute appointments, or 'block bookings'. This offer was made in cases where the practitioner was 'uncertain' of the underlying problem and 'suspicious' that there was an underlying social or psychological disturbance. The attached worker's investigative assessment and supportive skills were of practical utility to the participants as she reduced patient demand for follow-up and non-routine appointment bookings.

A P P E N D I X B

PART ONE

Patient No. _____

Health Centre: A _____ B _____ Date: _____

- | | | |
|------------------------|-------------------|-----------|
| 1. Patient(s) Referred | 2. Date of Birth: | 3. Sex: |
| (a) _____ | (a) _____ | (a) _____ |
| (b) _____ | (b) _____ | (b) _____ |
| (c) _____ | (c) _____ | (c) _____ |
| (d) _____ | (d) _____ | (d) _____ |
| (e) _____ | (e) _____ | (e) _____ |

4. Address: _____

5. HOW DID THIS CASE COME TO YOUR ATTENTION?

A. Referral from G.P. (Please specify the name of the G.P.)

B. Referral from the Nurse (Please specify the name of the nurse)

(i) District Nurse _____

(ii) Practice Nurse _____

(iii) Health Visitor _____

(iv) Community Psychiatric Nurse _____

C. Clinical Psychologist _____

D. Patient's Self Referral _____

E. Referred by Parent/Guardian _____

F. Secretarial Staff _____

G. Other:

/(i)

- | | |
|-----------------------------|-------------|
| (i) Social Work Team | (i) _____ |
| (ii) Hospital Department | (ii) _____ |
| (iii) School Health Service | (iii) _____ |
| (iv) Other (Please Specify) | (iv) _____ |
-

6. WHAT METHOD WAS USED TO BRING THIS CASE TO YOUR ATTENTION?

A. Formal

- | | |
|--------------------------------|------------|
| (i) Standardised form | (i) _____ |
| (ii) Formal Letter of Referral | (ii) _____ |

B. Informal

- | | |
|----------------------------------------------------------|-------------|
| (iii) Note | (iii) _____ |
| (iv) Verbal Face to Face | (iv) _____ |
| (v) Telephone | (v) _____ |
| (vi) Via Third Person
(Please Specify e.g. Secretary) | (vi) _____ |
-

7. WHAT REASONS DID THE REFERRAL AGENT GIVE FOR BRINGING THIS CASE TO YOUR ATTENTION? (VERBATIM RECORDING PLEASE).

PART TWO

8. Client Unit:

(A) INDIVIDUAL

- | | |
|------------------------------|-----------------|
| (i) Child (1-12 yrs.) | (i) _____ |
| (ii) Adolescent (13-15 yrs.) | (ii) _____ |
| (iii) Adult (16-64 yrs.) | (iii) _____ |
| | (a) 16-19 _____ |
| | (b) 20-29 _____ |
| | (c) 30-39 _____ |
| | (d) 40-49 _____ |
| | (e) 50-64 _____ |
| (iv) Elderly (65+) | (iv) _____ |

(B) COUPLE

(Married or co-habiting without
children or without children in
the parental home)

(i) _____

(C) FAMILY

- | | |
|------------------------------------------|-------------|
| (i) Single Parent with child | (i) _____ |
| (ii) Nuclear (Husband/Wife and children) | (ii) _____ |
| (iii) Extended (as nuclear + relation) | (iii) _____ |

9. Civil Status of Patient:

M _____ S _____ W _____ D _____ Sep. _____

10. Occupation of Head of Household:

(a) _____

Occupation of Patient:

(b) _____

11. WHERE WAS THE CLIENT SEEN?

- | | |
|-------------------|-------|
| (i) Health Centre | _____ |
| (ii) Home | _____ |

12. WHAT PROBLEMS DID YOU IDENTIFY?

13. WHAT ACTION DID YOU TAKE?

APPENDIX C

Interview Schedule

First Interview

Introduce study, purpose of interview and method of preserving confidentiality (adjust interview for setting/occupation of informant).

1. Where did you go to medical school/train for CQSW/SEN/SRN/Health Visitor's Certificate? When did you graduate/qualify? Do you have any specialist qualifications (specify)? Did you practice before joining the health centre/area team? Describe.
2. With respect to the local social work department/health centres, have you referred any of your patients/received any referrals of patients to/from the department/health centres in the past month? Three months? Six months? Year? How many? Why were the patients referred? (Probe - describe in detail.) What did you expect/what did they expect the social worker to do? (Probe for detail.) What did he/she do/what did you do? What in your view should they have done?
3. How would you define the role of the social worker? Their tasks? Functions? (Probe - use checklist if informant fails to mention substantive area.) Do you think there are differences between the role of the general practitioner and the social worker? Describe. Health visitor? District nurse? Psychiatric nurse? Psychologist? Tasks? Philosophy/principles? Are there

similarities? What are they? (Probe for detail.) Checklist:

Sustaining functions;
Didactic action;
Provision material aid;
Liaison/co-ordination;
Supervision;
Guidance counselling;
Socio-psychological therapy;
Education;
Group work.

4. Have you received any referrals from the social work department/made any referrals to the health centres in the past month? Three months? Six months? Year? (Repeat questions above.)
5. Have you contacted the social work department/have the health care workers contacted the department for advice/information in the past month? Three months? Six months? Year? What advice/information were you/were they looking for? Were they able to provide you/did you provide them with the information/advice you/they required? (Probe - whether met expectations.)
6. Have you had any additional contact with individual social workers/health care staff in the past month? Three months? Six months? Year? Describe (probe for detail). Do you have regular formal/informal contact with individual social workers/health care workers? Could you name them? How often do you contact them? How is this contact maintained?

7. In summary, how would you describe your contact with the social work department/health centres? Your relationship with individual social workers/health care workers? What is the best thing about your relationship? What is the worst thing about your relationship? By and large, do you get along with the social workers/health care workers? Complaints?
8. Could you describe your attitude towards the attachment of a social worker to the health centre? Are you in favour of the proposal? Why do you say that? (Probe for detail.) What has led you to this position? What are the advantages of having an attached social worker? Disadvantages? Do you think your health centre/social work colleagues share your view? (Probe \$- why do you say that?)
9. Have you given any thought to the role the attached social worker might play in general practice? Does the social worker have a proper role to play? What is his/her role? (Probe - use checklist if informant fails to mention substantive area.)

Checklist:

- Sustaining functions;
- Didactic action;
- Provision material aid;
- Liaison/co-ordination;
- Guidance counselling;
- Socio-psychological therapy;
- Education;
- Group work.

10. What do you think the attached social worker could offer the patient? General practitioner? Health visitor? District nurse? Psychiatric nurse? Psychologist? What should an attached social worker provide the health centre? Specialist teams? Are there any particular priorities that the attached social worker should observe? What are they? How have you dealt with/managed to deal with this work/problems in the past without an attached social worker? (Probe for detail.)
11. Do you think you will gain professionally from having/being an attached social worker? What do you expect to gain? Personally? Expectation? The health centre? Expectation? The area team? Expectation? Do you think that your colleagues share your view? (Probe for detail.)
12. What do you look for in order to define attachments a success?

Second Interview

Health care workers. Rephrase and repeat questions 2-11 from first interview taking account of time (past-tense) and experience.

12. Evaluation of the attachment? Reasons? Have you experienced any problems of adjustment? Describe. Has the attachment developed as you expected? Describe (probe for detail). What criteria would you use if you were choosing another social worker to take up a post here.

Second Interview

Social worker(s). Repeat questions 2-11.

12. Evaluation of the attachment? Reasons? What didn't you anticipate about work in the health centre? Have you had to make any adjustments? Area team? Knowing what you do now would you support/take up another attached post? Explain.
13. Has the social work administration helped you to adjust to the health centre? The area team? Were they useful to you? In what way? What problems have you taken to them? What problems should you be able to take to them?
14. Do your colleagues in the health centre have an accurate idea of your work with patients? In the health centre? Outside of the health centre? How do they know? Your colleagues in the social work department? How do they know?

B I B L I O G R A P H Y

- ALASZEWSKI, A. (1977). 'Doctors and Para-medical Workers - The Changing Pattern of Inter-professional Relations'. Health and Social Services Journal, 14 October
- ALLAN, R.W., MADISON, D.L., PORTER, L.W., RENWICK, P.A. and MAYES, B.T. (1979). 'Organisational Politics: Tactics and Characteristics of its Actors'. California Management Review, 22, V77-83.
- ANDERSON, S.A. and HASLER, C.S. (1979). 'Counselling in General Practice'. Journal of the Royal College of General Practitioners, 29, 352-6.
- ARMSTRONG, D. (1976). 'The Decline of Medical Hegemony: a Review of Government Reports During the N.H.S.'. Social Science and Medicine, 10, 157-63.
- ARMSTRONG, L. (1979). 'How to Avoid Burnout in Child Abuse and Neglect'. The International Journal of Child Abuse and Neglect. B
- ATKINSON, M.J. (1971). 'Societal Reactions to Suicide: The Role of Coroners' Definitions'. In Cohen, S. (ed.) Images of Deviance. Harmondsworth, Middlesex: Penguin.
- ATKINSON, P. (1977). 'The Reproduction of Medical Knowledge'. In Dingwall, R., Health, C., Reid, M. and Stacey, M. (eds.) Health Care and Health Knowledge. London: Croom Helm.
- BADDELEY, A. (1979). 'The Limitations of Human Memory: Implications for the Design of Retrospective Surveys'. In Moss, L. and Goldstein, H. (eds.). The Recall Method in Social Surveys. London: University of London Institute of Education.
- BADDELEY, A. D. (1976). The Psychology of Memory. New York: Basic Books.
- BAILEY, R. and BRAKE, M. (1975). 'Radical Social Work'. London: Edward Arnold.
- BEALES, J.G. (1976). 'Practical Sociological Reasoning and the Making of Social Relationships among Health Centre Participants'. In Stacey, M. (ed.). The Sociology of the NHS. Keele: University of Keele.
- BEALES, J.G., ETHERIDGE, J., FIELD, D. and HICKSON, D.J. (1976). The Microcosm: Health Centres in Practice. University of Bradford: Organisational Analysis Research Unit.
- BEALES, J.G. (1978). Sick Health Centres and How to Cure Them. London: Pitman Medical.
- BECKER, H.S. (1971). Sociological Work. London: The Penguin Press.

- BENDIX, R. (1962). Max Weber: An Intellectual Portrait. Garden City, New York: Anchor Books.
- BEN-SARA, Z. (1976). 'The Function of the Professional's Affective Behaviour in Client Satisfaction: A Revised Approach to Social Interaction Theory'. Journal of Health and Social Behaviour, 17, 3-11.
- BERLANT, J.L. (1975). Profession and Monopoly: A Study of Medicine in the United States and Great Britain. Berkeley: University of California Press.
- BLAIR, P.M. (1964). Exchange and Power in Social Life. New York: John Wiley and son.
- BLOOR, M. (1976). 'Professional Autonomy and Client Exclusion'. In Robinson, D. and Wadsworth, M. (eds.) Studies in Everyday Medical Life. London: Martin Robinson.
- BODKIN, N.J., GAZE, R.B., GOMEZ, G., HOWLETT, M.J. and LEIGH, D. 'The General Practitioner and the Psychiatrist: A Study in Co-operation'. British Medical Journal, 2, 723.
- BRANDON, J. (1976). 'The Functions of the Hospital Based Social Worker'. Social Work Today, 1, 3, 10-17.
- BRITISH ASSOCIATION OF SOCIAL WORKERS (1979). The Social Work Task. London: BASW Publications.
- BRITISH MEDICAL ASSOCIATION (SCOTTISH OFFICE), (1977). Practice in Health Centres. Edinburgh.
- BRITISH MEDICAL JOURNAL (1965). The Family Doctor's Charter. Supplement.
- BROOKS, D. (1977). 'Social Workers Have Not Helped in Care in General Practice'. Update, 14.
- BRUCE, N. (1978). The Social Work/Medicine Interface. Social Work Service Group: Edinburgh.
- BRUCE, N. (1980). Teamwork for Preventative Care. Chichester: Research Studies Press.
- BUCHAN, I.C. and RICHMOND, I.M. (1973). Time Study of Consultations in General Practice - Scottish Health Service Studies No. 27. Edinburgh: Scottish Home and Health Department.
- BUCHAN, I.C., BUCKLEY, E.G., DEACON, G.L.S., IRVINE, R., RYAN, M.P. (1981). 'Problem Drinkers and their Problems'. Royal College of General Practitioners, 31, 151-153.
- BUCHER, R. (1970). 'Social Process and Power in a Medical School'. In Zald, M.N. (ed.). Power in Organisations. Nashville: Vanderbilt University Press, 3-48.

- BUCHER, R. and STELLING, J. (1969). 'Characteristics of Professional Organisations'. Journal of Health and Social Behaviour. 10, 1, 3-15.
- BURCHARD, W. (1954). 'Role Conflicts of Military Chaplains'. American Sociological Review, 29, 5.
- BURCHELL, G. (1981). 'Putting the Child in its Place'. I.E.C., 8, 73-95.
- BURNS, T. and STALKER, G. (1961). The Management of Innovation. London: Tavistock Publications.
- BURSILL, M. (1978). Assessment of Social Work Attachment. Stage 2. Research Section, Kent County Council.
- BUTRYM, Z. (1974). 'Ethical Standards in Counselling'. Social Work Today, 5, 13. 406-407.
- BUTRYM, Z. (1967). Social Work in Medical Care. London: Routledge and Kegan Paul.
- BUTRYM, Z. and HORDER, J. (1983). Health, Doctors and Social Workers. London: Routledge and Kegan Paul.
- CARPENTER, M. (1977). 'The New Managerialism and Professionalism in Nursing'. In Stacey, M. and Reid, M. (eds.), Health and the Division of Labour. London: Croom Helm.
- CENTRAL HEALTH SERVICES COUNCIL (1954). Report of the Committee on General Practice within the National Health Service. (Cohen Committee). London: H.M.S.O.
- CHERNESS, C. (1980). Staff Burnout : Job Stress in the Human Services. Beverly Hills, California: Sage Publishers.
- COCHRANE, A.L. (1972). Effectiveness and Efficiency: Random Reflections on Health Services. London: Nuffield Provincial Hospitals Trust.
- COLEMAN, J., KATZ, E., MENZEL, H. (1957) 'The Diffusion of an Innovation among Physicians'. Sociometry, 21, 253-69
- COLLINS, J. (1965). Social Casework in a General Medical Practice. London: Pitman Medical.
- COMMON SERVICES AGENCY (1975). Health Centres in Operation, 31 December for Scottish Health Service, Edinburgh, (mimeo).
- COOK, K.S., EMMERSON, R.M., GILLMORE, M.R. and YAMAGASHI, T. (1983) 'The Distribution of Power in Exchange Networks: Theory and Experimental Results'. American Journal of Sociology. 89, 2, 275-305
- COOPER, B. (1972a). 'Clinical and Social Aspects of Chronic Neurosis'. Practitioner, 208.

- COOPER, B. (1972b). 'Social Correlates of Psychiatric Illness in the Community'. In McLachlan, G. (ed.), Approaches to Action: A Symposium on Services for the Mentally Ill and Handicapped. London: Oxford University Press for Nuffield Provincial Hospitals Trust.
- CORNEY, R.H. (1980A). 'Factors Affecting the Operation and Success of Social Work Attachment Schemes to General Practice'. Journal of the Royal College of General Practitioners, 30, 212.
- CORNEY, R.H. (1980b). 'The Social Worker and the Health Visitor'. Social Work Today.
- CORNEY, R.H. (1983). 'Health Visitors and Social Workers'. In Clare, A.W. and Corney, R.H.(eds.). Social Work and Primary Health Care. London: Academic Press.
- CORNEY, R.H. and BOWEN, B.A. (1980). 'Referrals to Social Workers: A Comparative Study of a Local Authority Intake Team with a General Practice Attachment Scheme'. Journal of the Royal College of General Practitioners, 30, 139-147.
- CORNEY, R. H. and BRISCOE, M.E. (1977a). 'Investigation into Two Different Types of Attachment Scheme'. Social Work Today, 1:5.
- CORNEY, R. and BRISCOE, M. (1977b). 'Social Workers and their Clients: Comparison between Primary Health Care and Local Authority Settings'. Journal of the Royal College of General Practitioners, 27.
- CROZIER, M. (1963). The Bureaucratic Phenomenon. Chicago: University of Chicago Press.
- CYERT, R. and MARCH, J.C. (1963). A Behavioural Theory of the Firm. Englewood Cliffs, N.J.: Prentice Hall.
- DAY, P.R. (1981). Social Work and Social Control. London: Tavistock Publications.
- DAHL, R.A. (1957). 'The Concept of Power'. Behavioural Science, 2, 201-215.
- DAHRENDORF, R. (1959). Class and Class Conflict in Industrial Society. Stanford, California: Stanford University Press.
- DAVIES, C. (1972). 'Professionals in Organisations: Some Preliminary Observations on Hospital Consultants'. Sociological Review, 70, 4, 553-567.
- DAVIES, M. (1981). The Essential Social Worker: A Guide to Positive Practice. London: Heinemann Educational Books.
- DENZIN, N.K. (1970). The Research Act: A Theoretical Introduction to Sociological Methods. New York: Aldine.

- D.H.S.S. (1959). Report of the Working Party on Social Workers in the Local Authority Health and Welfare Service. London: H.M.S.O.
- D.H.S.S. (1968). Report of the Committee on Local Authority and Allied Personal Social Services. (Seebohm Report). London: H.M.S.O.
- D.H.S.S. (1969). Report of the Working Party on Management Structure in the Local Authority Nursing Services. (Maytson Report). London: Department of Health and Social Security.
- D.H.S.S. (1974). Report of the Committee of Inquiry into the Care and Supervision Provided in Relation to Maria Colwell. London: H.M.S.O.
- D.H.S.S. (1975). Report of the Committee of Inquiry into the Provision and Co-ordination of Services to the Family of John George Aukland. London: H.M.S.O.
- D.H.S.S. (1976). Regional Planning Division: J.C.C. Review. London: H.M.S.O.
- D.H.S.S. (1978). Social Service Teams: The Practitioner's View. London: H.M.S.O.
- D.H.S.S. (1979). Relations with Social Services. (RD3). London: D.H.S.S./Social Work Services.
- DIMMOCK, S. (1977). 'Participation or Control? The Worker's Involvement in Management'. Barnard, K. and Lee, K. (eds.) Conflicts in the National Health Service. London: Croom Helm, 121-144.
- DINGWALL, R. (1976). 'Accomplishing Profession'. The Sociological Review, 24, 331-45.
- DINGWALL, R. (1977). 'Atrocity Stories and Professional Relationships'. Sociology of Work and Occupations, 4, 4, 371-96.
- DINGWALL, R. (1977). The Social Organisation of Health Visitor Training. London: Croom Helm.
- DINGWALL, R. (1983). 'Problems of Teamwork in Primary Care'. In Clare, A.W. and Corney R.H. (eds.) Social Work and Primary Health Care. London: Academic Press.
- DOPSON, L. (1971). The Changing Scene in General Practice. London: Johnson.
- ECKSTEIN, H. (1959). The English Health Service. Connecticut: Harvard University Press.
- EDITORIAL (1978). 'G.M.S.C. to Devise New Policy on Health Centres'. March 31, 1.

- EHRlich, D. and SABSHIN, M. (1964). 'A Study of Sociotherapeutically Oriented Psychiatrists'. American Journal of Ortho Psychiatry, 34, 3.
- ELSTON, M.A. (1974). 'Medical Autonomy: Challenge and Response'. In Barnard, K. and Lee, K. Conflicts in the National Health Service. London: Croom Helm, 26-51.
- EMERSON, R.M. (1962). 'Power-Dependence Relations'. American Sociological Review, 27, 31-41.
- EMERSON, R.M. (1972). 'Exchange Theory, Part II: Exchange Relations and Networks'. In Berger, J., Zelditch, M. and Anderson, B. (eds.) Sociological Theories in Progress. Boston: Houghton Mifflin.
- FAHY, J. (1974). 'Pathways of Specialist Referral of Depressed Patients from General Practice'. British Journal of Psychiatry, 124.
- FAULDS, M. (1976). Social Work in Health Centres. Strathclyde Regional Council Social Work Department.
- FERRIS, P. (1975). The Doctors. London: Victor Gollancz Ltd.
- FIRTH, R. (1975). 'Under One Roof'. Health and Social Services Journal, 9th August.
- FLETCHER, C. (1974). Beneath the Surface: An Account of Three Styles of Sociological Research. London: Routledge and Kegan Paul.
- FOLLIS, P. (1978). 'A Health Centre Now Means Primary Care Plans for Glasgow'. Pulse, 76, 1, Jan.
- FOREN, R. and BAILEY, R. (1968). Authority in Social Casework. Oxford: Pergamon.
- FORMAN, J.A.S. and FAIRBAIRN, E.M. (1968). Social Casework in General Practice. London: Oxford University Press.
- FORSYTH, G. (1973). Doctors and State Medicine. 3rd ed. London: Pitman Medical.
- FOX, R. (1975). 'Training for Uncertainty'. In Cox, C. and Mead, A. (eds.) A Sociology of Medical Practice. London: Collier-Macmillan.
- FREIDSON, E. (1970). Professional Dominance. New York: Atherton.
- FREIDSON, E. (1971). 'Applications of Organizational Theory to Health Care'. In Sokolowski, M. (ed.) Society, Health and Medicine. Dordrecht, West Germany: Reidel.
- FREIDSON, E. (1972). The Profession of Medicine. New York: Dodd Mead and Co.

- FREIDSON, E. (1973a). 'Professionalization and the Organization of Middle-class Labour in Post-industrial Society'. In Halmos, P. (ed.) Professionalisation and Social Change. Sociological Review Monograph 20. Keele: University of Keele, 47-60.
- FREIDSON, E. (1973b). 'Pre-paid Group Practice and the New 'demanding' Patient'. Millbank Memorial Fund Quarterly/Health and Society, 5. Fall, 473-480.
- *FREIDSON, E. (1975). Doctoring Together. New York: Elsevier.
- FREIDSON, E. (1977). 'The Futures of Professionalisation'. In Stacey, M. and Reid, M. (eds.) Health and the Division of Labour. London: Croom Heal, 14-40.
- FRY, J. (1976). 'An Overview of Primary Health Care'. International Journal of Health Services, 16, 2.
- GIDDENS, A. (1968). "Power" in the Recent Writings of Talcott Parsons'. Sociology, 2, 257-70.
- GIDDENS, A. (1976). New Rules of Sociological Methods, London: Hutchinson.
- GILCHRIST, I.C., GOUGH, J.B., HORSFALL-TURNER, Y.R., INESON, E.M., KEELE, E.M., KEELE, C., MARKS, B. and SCOTT, H. (1983). 'Social Work in Primary Medical Care'. In Clare, A.W. and Corney, R.H. (eds.). Social Work and Primary Medical Care. London:
- GILL, D. and HOROBING. (1972). 'Doctors, Patients and the State: Relationships and Decision Making'. Sociological Review, 20, 4, 505-20.
- GILMORE, M., BRUCE, N., and HUNT, M. (1974). The Work of the Nursing Team in General Practice. London: Council for the Education and Training of Health Visitors.
- GODBER, G. (1975). The Health Service, Past, Present and Future. London: Athlone Press.
- GOLDBERG, D.P. and BLACKWELL, B. (1970). 'Psychiatric Illness in General Practice: A Detailed Study using a New Method of Case Identification'. British Medical Journal, 2.
- GOLDBERG, E.M. and NEILL, J.E. (1972). Social Work in General Practice, London: George Allen and Unwin.
- GOULSTONE, R. and JONES, E. (1976). General Practitioners' Social Services Liaison. Case Studies of the Schemes in South Dorset. In Clearing House for Local Authority Social Research, no. 7.
- GROSS, N.C., MASON, W.S. and MCEACHORN, A.W. (1958). Explorations in Role Analysis: Studies of the School Superintendency Role. New York: John Wiley and Sons.
- HABENSTEIN, R.W. (1970) (ed.). Pathways to Data: Field Methods for Studying Ongoing Social Organizations. Chicago: Aldine.

- HALPIN, A.W. and CROFT, D.B. (1963). The Organizational Climate of Schools. Chicago: Midwest Administrative Centre, University of Chicago.
- HANDY, C.B. (1976). Understanding Organisations, London: Penguin Educational Books.
- HANNAY, D.R. (1979). The Symptom Iceberg. London: Routledge and Kegan Paul.
- HARWIN, B.G., COOPER, B., EASTWOOD, M.R. and GOLDBERG, D.F. (1970). 'Prospects for Social Work in General Practice'. Lancet no.2.
- HAUG, M. (1976). 'Issues in General Practitioner Authority in the National Health Service'. In Stacey, M. (ed.) The Sociology of the N.H.S. Sociological Review Monograph no. 22. Keele: University of Keele.
- HAUG, M. (1978). 'Issues of Patient Acceptance of Physician Authority in Great Britain'. In Gallagher, E.B. (ed.). The Doctor--Patient Relationship in the Changing Health Scene. Washington, D.C.: U.S. Government Printing Office, 239-254.
- HERAUD, B. (1979). Sociology in the Professions. London: Open Books.
- HERSHEY, N. (1972). 'The Defensive Practice of Medicine: Myth or Reality'. Millbank Memorial Fund Quarterly, 50. 69-98.
- HEY, A. and ROWBOTTOM, R. (1977). 'Task and Supervision in Area Social Work'. In Fitzgerald, M., Halmos, P., Muncie, J. and Zelden, D. Welfare in Action. London: Routledge and Kegan Paul.
- HICKS, D. (1976). Primary Health Care: A Review. London: H.M.S.O.
- HICKSON, D.J., HININGS, C.R., LEE, C.A., SCHMECK, R.H. and PENNINGS, J.M. (1971). 'A Strategic Contingencies' Theory of Intraorganizational Power'. Administrative Science Quarterly. 16, 216-229.
- HINDESS, B. (1973). The Use of Official Statistics in Sociology. London: Macmillan.
- HINDLEY, C.B. (1979). 'Problems of Interviewing in Obtaining Retrospective Information'. In Moss, L. and Goldstein, H. (eds.) The Recall Method in Special Surveys. London: University of London Institute of Education.
- HOGHUGH, M. (1979). 'Myth, Method and Utility'. Social Work Today, 10, 29, 11-17.
- HOGHUGH, M. (1980a). 'Social Work in a Bind - The Nature of the Task'. Community Care, 310, 27-32.
- HOGHUGH, M. (1980b). 'Social Work in a Bind - A Way Out'. Community Care, 311, 22-27.

- HONIGSBAUM, F. (1979). The Division in British Medicine: A History of the Separation of General Practice from Hospital Care 1911 - 1968. London: Kogan Page.
- HOPKINS, P. (1974). Update, 8, 348.
- HOROBIN, G. and MCINTOSH, J. (1977). 'Responsibility in General Practice'. In Stacey, M., Reid, M., Heath, C. and Dingwall, R. Health and the Division of Labour. London: Croom Helm. 88-114.
- HUGHES, D. (1977). 'Everyday and Medical Knowledge in Categorising Patients'. In Dingwall, R., Heath, C., Reid, M. and Stacey, M. (eds.) Health and Health Knowledge, 127 - 140.
- HUNTER, D. (1979). 'Decisions and RESources in Health Care'. Sociology of Health and Illness, 1, 1, 40-61.
- HUNTINGTON, J. (1981). Social Work and General Medical Practice: Collaboration or Conflict. London: Allen and Unwin.
- ILLICH, I. (1975). Medical Nemesis: The Expropriation of Health. London: Marion Boyers.
- ILLICH, I. (1977). 'Disabling Professions'. In Illich, I. Disabling Professions. London: Marion Boyers.
- INSTITUTE FOR SOCIAL RESEARCH (1969). Interviewer's Manual. Ann Arbor, Michigan: University of Michigan, Survey Research Centre.
- IRVINE, R. (1979). 'Medical' Decision Making by Non-Medical Staff: The Receptionist in General Practice. (Presented to B.S.A. Medical Sociology Group Annual Conference, Warwick).
- IRVINE, R. (1982). 'Images of Social Work'. Working paper (unpublished), Edinburgh: Moray House College of Education.
- JAMES, R.W. (1961). 'A Note on Phases of the Community Role of the Participant Observer'. American Sociological Review, 26, 446-450.
- JAMOUS, H. and PELOILLE, B. (1970). 'Professions or Self-perpetuating Systems? Changes in the French University Hospital System'. In Jackson J.A.(ed.) Professions and Professionalization. Cambridge: Cambridge University Press.
- JEFFERYS, M. (1976). 'The Doctor's Dilemma, a Sociological Viewpoint'. In Cox, C. and Mead, A. (eds.) A Sociology of Medical Practice. London: Collier: Macmillan, 145-154.
- JENKINS, M.E. (1978). The Attachment of Social Workers to G.P. Practices. Research Section, Mid Glamorgan County Council.
- JOHNSON, M.L. (1977). 'Patients: Receivers or Participants?'. In Barnard, K. and Lee, K. (eds.). Conflicts in the National Health Service. London: Croom Helm, 72-91.

- JOUVENEL, B. de (1958). 'Authority: The Efficient Imperative'. In Freidrich, C.J. (ed.). Authority. Cambridge, Mass.
- KAESER, A.C. and COOPER, B. (1971). 'The Psychiatric Patient, the General Practitioner, and the Outpatient Clinic: an Operational Study and Review'. Psychological Medicine, 1.
- KOCH, K.C.H. (1979). 'Evaluation of Behaviour Therapy Intervention in General Practice'. Journal of the Royal College of General Practitioners, 28, 667-76.
- LACEY, C. (1976). 'Problems of Sociological Fieldwork'. In Shipman, M. (ed.) The Organization and Impact of Social Research: Six Original Case Studies in Education and Behaviour. London: Routledge and Kegan Paul, 63-88.
- LAMBERTS, H. and RIPHAGEN, F.E. (1975). 'Working Together in a Team for Primary Health Care - A Guide to Dangerous Country'. Journal of the Royal College of General Practitioners, 25.
- LASSWELL, H. and KAPLAN, A. (1950). Power and Society. New Haven: Yale University Press.
- LENN, M., BLAMPIED, A., ANDERSON, M. (1984). Draft Report on Roles of Staff in Voluntary Organizations Concerned with the Personal Social Services in Scotland. Unpublished, University of Dundee.
- LINDSEY, A. (1962). Socialized Medicine in England and Wales. The N.H.S 1948-1961. Oxford: Oxford University Press.
- LUKES, S. (1974). Power: A Radical View. London: Macmillan.
- LUKES, S.F. (1977). Essays in Social Theory. New York: Columbia University Press.
- MCCALL, C.J., and SIMMONS, J.L. (1969) (eds.). Issues in Participant Observation: A Text and Reader. London: Addison-Wesley.
- MCCULLOCH, J.W. and BROWN, M.J. (1970). 'Social Work in General Medical Practice'. Medical Social Work, 22, -, 300-303.
- McKEOWN, T. (1971). 'A Sociological Approach to the History of Medicine'. In McLachlan, G. and McKeown, T. (eds.), Medical History and Medical Care. Oxford: Nuffield Provincial Hospitals Trust, 1-16.
- MARCH, J.C. (1966). 'The Power of Power'. In Easton, D. (ed.) The Varieties of Political Theory. Englewood Cliffs, New Jersey: Prentice Hall.
- MARCH, J.C. (1978). 'Bounded Rationality, Ambiguity and the Engineering of Choice'. Bell Journal of Economics, -, 587-609.
- MARSHALL, M. and HARGREAVES, M. (1979). 'So you Want to Try a G.P. Attachment'. Social Work Today, 10, 42.

- MARX, K. (1962). Capital. Moscow: Foreign Languages Publishing House.
- MAYER, J. and TIMMS, N. (1970). The Client Speaks. London: Routledge and Kegan Paul.
- MECHANIC, D. (1962). 'Sources of Power of Lower Participants in Complex Organizations'. Administrative Science Quarterly, 7, 349-364.
- MECHANIC, D. (1968). Medical Sociology: A Selective View. New York: The Free Press.
- MECHANIC, D. (1970). 'Correlates of Frustration among British General Practitioners'. Journal of Health and Social Behaviour, 11, 2, 87-104.
- MECHANIC, D. (1974). Politics, Medicine and Social Science. New York: John Wiley and Son.
- MECHANIC, D. (1975). 'Practice Orientations among General Practitioners in England and Wales'. In Cox, C. and Mead, A. (eds.). A Sociology of Medical Practice. London: Collier-Macmillan, 132-144.
- MECHANIC, D. (1975). Medical Sociology. Second Edition. New York: The Free Press.
- MILLS, C. WRIGHT (1956). The Power Elite. New York: Oxford University Press.
- MUKERJI, C. (1976). 'Having the Authority to Know: Decision Making on Student Film Crews'. Sociology of Work and Occupations, 3, 1, 63-87.
- NACMAN, M. (1975-76). 'A Systems Approach to the Provision of Social Work Services in Health Settings: Part 2'. Social Work in Health Care, 1, 2, 133-143.
- NAGEL, J. (1976). 'Description and Explanation in Power Analysis'. In Burns, T. and Buckley, W. (eds.). Power and Control: Social Structures and their Transformation. London: Saga Publications, 85-102.
- NATIONAL INSTITUTE FOR SOCIAL WORK (1982). Report of a Working Party into Social Workers: Their Roles and Tasks. (Barclay Report). London: Bedford Square Press.
- OLDHAM, G.R. and BEASS, D.J. (1979). 'Employee Reactions to an Open-Plan Office: A Naturally Occurring Quasi-Experiment'. Administrative Science Quarterly, 24, 267-284.
- OLSEN, R.M. and OLSEN, M.E. (1967). 'Role Expectations and Perceptions for Social Workers in Medical Settings'. Social Worker, 12, 3, 70-78.
- PARRY, N. and PARRY, J. (1975). The Rise of the Medical Profession. London: Croom Helm.

- PERROW, C. (1970). 'Departmental Power and Perspectives in Industrial Firms'. In Zald, M.N. (ed.). Power in Organizations. Nashville: Vanderbilt University Press, 58-89.
- PETTES, D.S. (1979). Staff and Student Supervision: A Task-Centred Approach. (National Institute of Social Services Library, No. 43). London: George Allen and Unwin.
- PFEFFER, J. (1981). Power in Organizations. Massachusetts: Pitman Publishing.
- PINCUS, A. and MINAHAN, A. (1973). Social Work Practice: Model and Method. Itasca, Illinois: F.E. Peacock, Publishers.
- PRINS, H.A. and WHYTE, M.B.A. (1972). Social Work and Medical Practice. Oxford: Pergamon Press.
- RATHJE, W.L., and HUGHES, W.W. (1975). 'A Garbage Project as a Non-reactive Approach: Garbage in .. Garbage Out'. In Smarko, H.N. and Broelding, L.A. (eds.). Perspectives on Attitude Assessment: Surveys and their Alternatives. Manpower and Advisory Services Smithsonian Institution Technical Report No. 2.
- RATOFF, L., ROSE, A. and SMITH, C. (1974). 'Social Workers and General Practitioners - Some Problems of Working Together'. Journal Royal College of General Practitioners, No. 24.
- RAWNSLEY, E.H. and LOUDON, J.B. (1962). 'Factors Influencing the Referral of Patients to Psychiatrists by General Practitioners'. British Journal of Preventative Social Medicine, 16, 174.
- REES, S. (1974). 'No More than Contact'. British Journal of Social Work, 4, 3.
- REES, S. and EDWARDS, F. (1973). 'Power and Influence in Social Work'. Social Work Today, 3, 21, 17-20.
- REES, S. (1978). Social Work Face to Face. London: Edward Arnold.
- REINACH, E. (1982). 'Organisations \$ An Overview of Research'. In Research Highlights No. 4. Social Work Departments as Organizations. Aberdeen: University of Aberdeen, 82-96.
- RESNICK, H. and PATTI, R.S. (1980). Change from Within: Humanising Social Welfare Organizations. Temple University Press.
- RICKARDS, C., GILDERSLEEVE, C., FITZGERALD, R. and COOPER, B. (1976). 'The Health of Clients of a Social Service Department'. Journal Royal College of General Practitioners, 26, 237-243.
- ROBERTS, E. (1982). 'A Presentation of Perspectives of Organisational Theory Relevant to Social Work'. In Research Highlights No. 4. Social Work Departments as Organizations. Aberdeen: Aberdeen University Press.

- ROBERTS, G., REINACH, E. and LOVELOCK, R. (1976). Children on the Rates. Social Services Research and Intelligence Unit. Portsmouth.
- ROBINSON, D. and WADSWORTH, M. (1976). Studies in Everyday Medical Life. London: Martin Robinson.
- ROSENGREN, W.R. and LEFTON, M. (1970). Organizations and Clients: Essays in the Sociology of Service. Ohio: Charles Merrill.
- ROY, R.G. (1967). 'Some Problems of Relationship: General Practitioners and Social Workers'. Case Conference, 14, 1, 264
- ROYAL COLLEGE OF GENERAL PRACTITIONERS (1970). Present State and Future Needs of General Practice. (Report No. XIII).
- ROYAL COLLEGE OF GENERAL PRACTITIONERS (1972). The Future General Practitioner. London: British Medical Journal for the Royal College of General Practitioners.
- ROYAL COLLEGE OF GENERAL PRACTITIONERS (1976). Discussion Document on Evidence to the Royal Commission on the National Health Service. London: Royal College of General Practitioners.
- ROYAL COMMISSION ON MEDICAL EDUCATION (1968). 1965-1968 Report (Todd Report) C.M.N. 356. London: H.M.S.O.
- RUSHINGS, W. (1964). The Psychiatric Professions. Chapel Hill: University of North Carolina Press.
- SARASON, S., CARROL, C., MATON, K., CHOEN, S. and LORENTZ, E. (1978). Resources, Community and Exchange Networks. San Francisco: Jossey Boss.
- SATYAMURTI, E. (1981). Occupational Survival: The Case of the Local Authority Social Worker. Oxford: Blackwell.
- SCHATZMAN, L. and STRAUSS, A. (1963). 'A Sociology of Psychiatry: A Perspective and Some Organizing Foci'. Social Problems, 14, 1, 3, 16.
- SCHATZMAN, L. and STRAUSS, A.L., (1973). Field Research: Strategies for a Natural Sociology. Englewood Cliffs, New Jersey: Prentice Hall.
- SCOTTISH EDUCATION DEPARTMENT (SED) SOCIAL WORK SERVICES GROUP (1976). Report of the Working Party on Social Work Services in the Scottish Health Service. Edinburgh: H.M.S.O.
- SCOTTISH HOME AND HEALTH DEPARTMENT (1966). Health and Welfare Services in Scotland. Edinburgh: H.M.S.O.
- SCOTTISH HOME AND HEALTH DEPARTMENT (1975). Health Services in Scotland: Report for 1974. (Comnd. 6052). Edinburgh: H.M.S.O.

- SCOTTISH INFORMATION OFFICE (1976). The National Health Service in Scotland. Edinburgh: Reference Unit.
- SHEPARD, M. (1972). 'Mental Illness, General Practice and the National Health Service'. In McLachlan, G. (ed.) Approaches to Action. London: Oxford University Press for Nuffield Provincial Hospitals Trust.
- SHEPARD, M., COOPER, B., BROWN, A.L. and KASTON, G. (1966). Psychiatric Illness in General Practice. London: Oxford University Press.
- SIMPKIN, M. (1979). Trapped within Welfare: Surviving Social Work. London: Macmillan.
- SMITH, G. (1979a). Social Work and the Sociology of Organizations. Revised edition. London: Routledge and Kegan Paul.
- SMITH, G. (1979b). Discretionary Decision-Making in Social Work. Discussion paper for S.S.R.C. Workshop on Discretionary Decision-Making. Downing College, Cambridge.
- SMITH, H. (1981). 'Crisis in an Institutional Network: Community Health Care'. In Becher, H.S. (ed.). Institutions and the Person: Essays Presented to Everett C. Hughes. Chicago: Aldine, 157-164.
- SMITH, H.W. (1975). Strategies of Social Research. Englewood Cliffs, New Jersey: Prentice Hall.
- SOFER, C. (1972). Organizations in Theory and Practice. London: Heinemann.
- SPECHT, H. and VICKERY, A. (eds.) (1977). Integrating Social Work Methods. London: Allen and Unwin.
- STACEY, M. (1976). 'The Health Service Consumer. A Sociological Misconception'. In Stacey, M. (ed.). The Sociology of the National Health Service. Staffordshire: University of Keele.
- STARK MURRAY, D. (1971). Why a National Health Service? London: Pemberton Books.
- STAW, B.M., and ROSS, J. (1980). 'Commitment in an Experimenting Society: An Experiment on the Attribution of Leadership from Administrative Scenarios'. Journal of Applied Psychology, 65, 249-260.
- STEVENS, R. (1966). Medical Practice in Modern England. New Haven: Yale University Press.
- STIMSON, G.V. (1978). 'Interaction between Patients and General Practitioners in the United Kingdom'. In Gallagher, E.B. (ed.). The Doctor-Patient Relationship in the Changing Health Scene. Washington, D.C.: U.S. Government Printing Office.

- STIMSON, G.C. and WEBB, B. (1975). Going to See the Doctor: The Consultation Process in General Practice. London: Routledge and Kegan Paul.
- STRATHCLYDE REGIONAL COUNCIL (1981). Social Work in Health Centres.
- STRAUSS, A., SCHATZMAN, L., BUCHER, R., EHRLICH, D., and SABSHIN, M. (1964). Psychiatric Ideologies and Institutions. London: Free Press.
- TANNENBAUM, A. (1968). Control in Organizations. New York: McGraw Hill.
- TAVISTOCK INSTITUTE OF HUMAN RELATIONS (1972). N.H.S. Manpower in Scotland - An Overview. London: Institute of Operational Research.
- THIBAUT, J.W. and KELLEY, H. (1959). The Social Psychology of Groups. New York: John Wiley and Sons.
- THOMPSON, J.D. (1967). Organizations in Action. New York: McGraw Hill.
- TIBBET, J. (1975). The Social Work Medicine Interface. A Review of Research. Edinburgh: Social Work Services Group.
- VAN de VEN, A.H., WALKER, G. and LISTON, J. (1979). 'Co-ordination Patterns within Inter-organizational Network'. Human Relations, 32, 1, 193-6.
- WALKER, J.H. and McCLURE, L.M. (1969). 'Community Nurses' Views of General Practice Attachment'. British Medical Journal, 3, 584-587.
- WEBB, L. (1975). Co-ordination between Health and Personal Social Services. Working Paper, European Seminar, Austria.
- WEBER, M. (1947). The Theory of Social and Economic Organization. London: Oxford University Press.
- WEBER, M. (1968). Economy and Society. Vol. 1. New York: Bedminster Press.
- WEST, P. (1976). 'The Physical and the Management of Childhood Epilepsy', In Robinson, D. and Wadsworth, M. (eds.) Studies in Everyday Medical Life. London: Martin Robinson.
- WHITTINGTON, C. (1975). The Study of Organization and Occupation in Social Work: A Sociology of Action Perspective. University of Keele: M.A. Thesis.
- WHITTINGTON, C. (1983). 'Social Work in the Welfare Network: Negotiating Daily Practice'. British Journal of Social Work, 13, 265-256.

- WILLIAMS, P. and CLARE, A. (1979). 'Social Workers in Primary Health Care: the General Practitioner's Viewpoint'. Journal Royal College of General Practitioners, 29, 554-558.
- WRENCH, J. and IRVINE, R. (1984). 'Coronary Heart Disease: Account of a Preventative Clinic in General Practice'. Journal of the Royal College of General Practitioners, 34, 477-481.
- WRONG, D. (1979). Power: its Forms, Bases and Uses. Oxford: Basil Blackwell.
- ZELDITCH, M. (1962). 'Some Methodological Problems of Field Studies'. American Journal of Sociology, 68, 566-577.
- ZOLA, I.K. (1970). 'Medicine as an Institution of Social Control'. In Cox, C. and Mead, A. (eds.). A Sociology of Medical Practice. London: Collier-Macmillan, 170-188.
- ZUCKER, L.G. (1977). 'The Role of Institutionalization in Cultural Persistence'. American Sociological Review, 42, 726-743.